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THE OPEN DOOR HOSPITAL*

*Including Special Discussion of the Problem of Criminal Order Cases***

BY HERMAN B. SNOW, M.D.

The environment of a hospital must not harm the patient but create an atmosphere in which a treatment program can be carried out to the patient's greatest benefit and with the least number of obstacles. The usual mental hospital milieu removes responsibilities and duties from a patient and leaves him in a setting that is almost sterile and is devoid of everything that might in any way arouse ambition, activity, or spontaneity. The hospitals—by making the patients live in an atmosphere that is not normal in their usual environments, that is, an atmosphere of closed doors, barred windows, authoritarianism, punishments, restraint—superimpose new symptoms upon an already mentally ill person. The abnormal restraints and restrictions aggravate the already existing mental symptoms. What is even worse and more important is that in many hospitals these superimposed or aggravated symptoms which the writer sometimes calls institutionalitis, are usually symptoms that are being treated, while unfortunately the original mental illness for which the patient is in the hospital is usually lost in background and all too frequently never treated.

At St. Lawrence (N.Y.) State Hospital,† it was found that these superimposed and aggravated symptoms need not be grafted onto the patient's original mental illness. It was really one of the many results which were found as the philosophy and practice of an open door mental hospital progressed. The open door hospital is defined at St. Lawrence State Hospital as one where each ward is open at least eight hours a day, and usually—depending on the type of patient on the ward—as long as 12 to 16 hours a day. The patient is free to go without questioning directly to the outside areas where, again, there are no restrictions such as gates, fences or other confining apparatus.

*Read in part before the Conference on Mental Health Facilities and Progress, Montgomery, Alabama on February 16, 1961.

**The discussion of criminal order cases was presented at the Upstate Inter-Hospital Conference of the New York State Department of Mental Hygiene at Syracuse, N. Y. on April 5, 1960.

†Ogdensburg, N. Y.

The open door hospital restores freedom, dignity, and responsibility to the patient who has been behind locked doors, and does not take away from the newly-admitted patient his personal feelings of freedom and responsibility. Psychotic decompensation, in the form of aggression, excitement, suicide, depression, panic episodes and so on, which in the past was considered part of the psychotic syndrome per se, disappears to a great extent; and we have begun to realize that these were in reality superimposed symptoms on the original psychotic disability. When the superimposed symptoms are removed, one is in a better position to treat the original illness. In the case of a newly-admitted patient where these superimposed or aggravated symptoms are not even allowed to build up, it is much easier to treat the emotional illness which brought the patient to the hospital; and this, therefore, shortens the hospital stay.

It has been observed that many patients are just like children who are bidding for attention whether it is for the good or bad. In the past, at St. Lawrence, when visitors went through a ward they were accosted and greeted with excitement or profanity, and with pleading and begging, and were given an earful of the patients' delusions and hallucinations, of how terrible conditions were and of how the patients were abused. Visitors would ask to see "the padded cells" and the dangerous patients. This all changes in an open hospital. Visitors go everywhere, and patients take visitors as a matter of routine. They greet visitors with, "Good morning," or, "Good afternoon." They talk about the hospital or about their families or the day's happenings; but rarely is there any interference with the visitors, as was the case previously. There is still, in many cases, a striking similarity in the behavior of patients who want to attract attention from a visitor, doctor or a nurse; and, underlying this, are some basic similarities; but the desire for attention is now expressed in conversation or in showing some accomplishment of occupational therapy or recreational therapy, rather than in the former yelling and screaming, accompanied by profanity or aggressive behavior.

When the ward doors were first opened, the patients felt they could do as they pleased. There was a lot of "back talk" to personnel on all levels, including the doctors, but after the patients became reoriented to the hospital and its facilities, they began to want to do more work in industry, occupational therapy and recrea-

tional therapy. They soon began to realize that with every privilege, they, in turn, had a responsibility to perform. It is true that in many elderly patients and in some of the younger, more confused individuals, this realization either came very slowly or not at all; but others, who were better oriented, assumed the responsibility of watching this type of patient. It was especially remarkable to note that in the elderly, confused patients, who it was feared, would get lost or wander away or get hurt, a sphere of limited orientation developed in spite of general disorientation and confusion. They seemed to learn how far they could go within their physical limitations, and where to return. It was also surprising to note that the more the elderly patients got around after the initial few months of wandering and getting lost, the more they became reoriented to time and place. It was surprising how many of these elderly people who had been sitting in chairs and doing nothing were suddenly remotivated. In the case of women, they might go to a beauty parlor, or sew and knit, or find some other occupation.

A visitor to St. Lawrence State Hospital at the present time almost immediately becomes aware of the conspicuous lack of noise, excitement and tension. The hospital is really seen in a cross-section of time and visitors have to be told of the longitudinal section. It is only after visitors talk to many of the patients and personnel members that they begin to realize that the patients they are talking to now were in restraint, or were idle and uncommunicative four or five years ago. There are times at present when a patient who has been in the hospital for a long time, or an occasional newly admitted patient, becomes excited or depressed or aggressive; but it is surprising how a word from a nurse to the patient, such as, "Be nice now, we have visitors," or, "Be still till we get these things out of the way," will quiet a patient until after the visitors leave, when he will immediately start in again to try to tell what is bothering him.

Most people who visit St. Lawrence come as unbelievers, but after two or three days at the hospital, really begin to see the truth of the matter. They come with a healthy apprehension, and in most cases, leave with a feeling that what they have seen can be accomplished in their own hospitals. Many visitors who are not on the administrative level appear to be frustrated when they return to their own hospitals. The open door is essentially

dependent upon the attitude of the director and his top-echelon people. If these people act indifferently, or shrug their shoulders, or are unwilling to assume the responsibility for the open door program, the rest of the hospital will gradually fall in line with them, and the result may be a hospital of custodial care and seclusion with its problems of aggression, escape, suicide, fighting and long-term patients. If the director and his immediate assistants have faith and a true desire to make the open hospital work, they can instill these in their people, overcome apprehension, and gradually change over to a more relaxed atmosphere and a better therapeutic community in which to treat the patient.

In the hospitals that have open doors, various methods have been used about how and when to inform the community, that is, before or after the fact. At St. Lawrence, the staff kept opening the doors until the community became aware of it and when, on community request, the public was told about it, the situation was accepted. Either way usually works pretty well, but the writer would note an exception in one place where he has talked. The director of this hospital was still a hard-boiled, security-custodial agent. His attitude permeated his entire staff and personnel, even though many had a great desire to open the doors and believed honestly that this would work in their hospital. The director's attitude, of course, permeated the community, and there was an immediate petition to ask the director to keep the doors closed and to put up a fence around the hospital. This is the only hospital that the writer knows of where this occurred; he feels very strongly that this is due only to the feelings of the man who was running this hospital.

In opening wards, some start with a well institutionalized group of patients, which is about what was done at St. Lawrence in 1956. If the writer had to do it over again, he would start by opening the reception service first. The depressed person who comes into the hospital has his depression increased by looking at grates and listening to the sound of keys. The patients very quickly become aware of the ritual of the key. They walk to the door like horses in a stable and then stand and wait for the key to turn. Delusional and paranoid patients have the opportunity to add to their suspiciousness and to include the hospital personnel in their trends because of the deprivation of their freedom.

In instituting the open door policy, administrators will soon find that they encounter all the problems they do not anticipate—although, as each such problem arises it seems to get solved without seeming to be a problem, and is recognized as one only in retrospect. On the other hand, all the problems that are foreseen either never occur, or occur in such slight degree as to be negligible or in such slight degree as even to be overlooked.

The writer knows some hospitals where a door to a ward is open and the patients come and go as they please; and then—because one new patient is admitted or because one patient becomes disturbed—the door is again closed for a few days until this one particular patient's problem can be settled. This is a very poor practice. A door to a ward, once opened, should never be closed unless the program is to be given up entirely. Closing a once-opened door just adds to the insecurity and suspiciousness of the patients. They begin to feel that it is a type of punishment. They begin to wonder if it will be opened again; and when it is opened, they are fearful as to when it may be closed again. Their situation is very much like that of a child whose father and mother are constantly threatening divorce, fighting and abusing each other, so that the child does not know where he stands. Such a situation, of course, leads to unnecessary tensions.

The open hospital has made a great deal of difference in the handling of patients and in the attitude of the personnel. At one hospital where the writer visited (and this would be typical of many), a young girl who had just been about to start college was admitted. She had become excited, worrisome, and somewhat depressed. She had had a love affair which had broken up when she was admitted to Hospital X, and the admission personnel were rather fearful that she might attempt suicide. She was put in a seclusion room with barred windows and a regular jail-like barred door with no furniture but a mattress. She became very excited, was assaultive, cried and screamed and stayed like this for 16 months. She gradually quieted down, improved and was removed from the seclusion area. She was questioned by visiting doctors, and she quietly told them that she resented very much the fact that she had been put into a "cage" and kept locked up. She said that when she came in she had been fearful and depressed and that the prison atmosphere in this seclusion room had only "added to everything." All her screaming and yelling and aggressiveness,

she contended, was not due to her illness but to the fact that she was so confined and so restricted in her freedom.

One may contrast this with the admission of a young woman to St. Lawrence State Hospital. This woman was in her very early thirties, she had been getting along very well; but, following some misfortunes in the family, a mental illness arose which was characterized by a feeling that people were against her, that somebody wanted to kill her and that the method of getting rid of her would be through some sort of poison gas. When she was admitted to St. Lawrence, she was brought in by police who had her handcuffed, and had her legs in shackles also, because she was so excited and aggressive that this was the only way they could control her. When she was placed on the admission ward, the nurse in charge asked the police to remove the restraints, and the police protested, saying that she would hurt someone if they did, that she should be in some sort of restraint. The nurse turned to the young woman, told her to be quiet and behave herself until they could get things organized and told her not to fight when they took the handcuffs off, that she was in a hospital where she must be treated.

The woman immediately quieted down, at least outwardly; the police removed the restraints and went on their way. The nurse turned to the patient and said, "You are all perspiring and messy. Let's go in and take a shower and get your hair fixed." This was done; clean clothes were put on the patient; and, all the time that this was going on, she was told that she was in a hospital where she was to be treated and sent home again. When asked why she was so aggressive toward the police, who certainly could protect her, she said they were not really police, they were people from the sky and that the reason she fought so hard was because she thought they were going to kill her. She stopped fighting when she came into the hospital, she said, because she recognized the nurse's uniform and felt that here was a protective place. She was asked to stay on the ward until the next morning, before going outside on the grounds; and it was explained that this was so she could get accustomed to the place and talk to the doctors about herself, and so that a definitive type of treatment could be established instead of the emergency treatment which was being given to her.

The patient remained quiet all night long, and the next morning was sitting quietly on the ward doing some sewing when she

suddenly got up, went quickly through the door, down the stairs and disappeared. The nurse in charge tried to follow her; but, by the time she got to the door and down the stairs, the patient was nowhere in sight. Because the patient had been so excited the day before, the nurse immediately reported this to the supervisor, the doctor and the hospital police, and a thorough search was made of the grounds; but the woman could not be found. About two hours later, as everyone was returning to the ward area, the patient was found sitting in a rocking chair on the porch, rocking merrily away and singing. Everyone, of course, was disturbed, and they started asking, "Where have you been in the last two hours?" Her answer was, "Right here, where have you been?"

She was asked why she left the ward and she replied that she felt that there was gas coming through one of the hot air registers. She had never seen a register before, thought the hot air blowing out had a peculiar smell like poison gas and wanted to get away from it. The nurse took her upstairs and explained that hot air came through the register, but the patient was fixed in her delusional trend, so she was taken to another ward in which the heating system was different and there were no registers. The nurse on this ward walked all around the area with the patient and asked if there was anything suspicious anywhere. The patient seemed satisfied that everything would be all right. From then on, she proceeded to make a good adjustment, and returned eventually to her home. One can easily see how, if this woman had been brought into some hospital in handcuffs (even to St. Lawrence five or six years ago), she might have been placed in the seclusion room and have remained there for months—a procedure that would have superimposed new symptoms on those which she already had. As it was, however, this was avoided by simply talking to the patient and getting her ideas.

One more case may be cited, that of a young man of 24, married with two children, who developed a mental illness in which he thought that he was the strongest man in the world. He grew a beard, refused to cut his hair and went around bragging about his strength, holding up his arms toward the sun and saying that he was receiving new power every day. On admission to the hospital, an effort was made to shave him and cut his hair but he immediately began putting up a great struggle, yelling and fight-

ing. When the writer, as director of the hospital, was told about it, he decided that as long as the man kept his growth of whiskers clean, and as long as he kept his hair combed and clean, to let him alone for the time being. Thereafter the patient was quiet but remained delusional, still feeling that he was the strongest man in the world, and that he had a mission to perform for the Lord. In other ways, he was always co-operative. He was placed on medication and on other forms of treatment; and after about four months, he was seen one day in the director's office sitting at the director's desk writing a note—much to the confusion, apprehension and fright of the writer's secretary. By the time the secretary called the switchboard and asked to have help to take the patient out of the office, the patient had gone. He had left a note on the desk addressed to the director of the hospital stating that he was going to get a haircut and shave, that he no longer felt that all of his strength would come through the sun, or through the hair on his face and head, and into his body. The patient then began to improve in other respects and shortly thereafter returned to his home in the community. Had this man been placed in some sort of restraint on admission, had he been shaved and had his hair cut, no doubt he would have looked better; but there is also no doubt in the writer's mind that his mental condition would have been correspondingly worse. He would have had to be kept in restraint because of his anger about the cutting of his hair and he probably would have been sick a great deal longer.

The open door gradually changes the attitudes and appearance of the patients; and, even though visitors may still find some who are a little messy or who are not dressed properly or whose attitudes are not just what they should be, what the visitors do not realize, in viewing a cross-section, is that these same patients, when considered in a longitudinal aspect, were many times worse previously. As new-found freedom continues for patients who have been in the hospital, they find their horizons of interest spreading, and as interest spreads to other patients, to the ward, to occupational therapy and to other spheres, their interest in their hallucinations and delusions becomes less marked. Their reminiscing and memory defects begin to disappear, and they begin to laugh and smile and show emotional reactions which are more appropriate . Patients are now interested in each other, in visitors, and in the personnel—as to where they are going, where

they are from, how long they are going to stay, where they bought a certain dress or a certain necktie, and so on. There is more natural conversation—which is the result of a resocialization program and the remotivation program—in the longer-stay patient. In the newly-admitted patient, the open door works by keeping him in touch with, and not allowing him to retreat from, reality.

A great problem which arose in the early part of 1958 was the criminal order case.* The main difficulty which delayed the opening of the last two closed wards was the admission of certain people under the Code of Criminal Procedure. Under this code, certain persons are admitted to the hospital on the order of a judge, in accordance with Sections 658 and 872, in order to determine the presence or absence of "insanity" and to determine whether or not a person is capable of consulting with his counsel. Up to June 1958 these people were kept on locked wards, and the hospital felt more or less responsible for their security.

In preparation for the opening of the last wards, a letter was sent to the judges, district attorneys, and as many others as could be reached, in the district served by the hospital, who were concerned with signing orders for observation under the Code of Criminal Procedure. In this letter, as will be seen, it was pointed out that the hospital was soon to become 100 per cent open and that it could not take the responsibility for the security of a person charged with a crime, while he was under observation at this hospital. Nor was it felt that it was fair to deprive 35 or 40 patients in a ward of their liberty, and keep them behind locked doors and barred windows, because of the presence of one, two or three persons sent to the hospital under criminal code order. In this problem was also the fact that 75 per cent or more of the persons admitted under this procedure were usually returned to the court as without mental disorder. It was further pointed out to the authorities that the hospital administrators would be very happy to arrange for examinations of these persons by appointment and report at once on the findings. It was further stated that should anyone be found mentally ill to the point where he was considered incapable of consulting with counsel or did not know the nature of his crime, the court would be informed immediately, and if certification was desired, the patient could then be admitted on a regular certification order. Everyone was most co-operative.

*See footnote (**) under subtitle of this paper.

All the courts, district attorneys and others concerned were satisfied with this new procedure, which was not, in fact, new in the state, since several other state hospitals had their doctors examine persons charged with crimes, either in jail, or at the hospital, or at some other convenient place, returning the persons so examined immediately to the custody of the court without having them ever enter the hospital. It also pleased many of the authorities because in this way there was no charge placed against a county for such a patient's maintenance at the hospital. The text of the director's letter to the criminal court authorities follows:

I am writing to you in regard to people who are sent to this hospital for observation under Section 658 or 872 of the Code of Criminal Procedure and all the other related paragraphs. This hospital has always tried to cooperate in these matters with all of the District Attorneys and all of the Courts. However, some difficulties have begun to arise at this hospital. For some time now prisoners have been brought in at one time, either late at night or over the week-ends, without any prior knowledge of this. This hospital, as you perhaps may know, has a very minimum amount of security and we certainly do not profess in any way to be able to take the responsibility for the security of any of these prisoners, although we do the best we can. There have been too many times now when there have been anywhere from six to 12 or 15 of these individuals who have been sent to the hospital within days, and as a result of it, a ward for mentally ill people has become a very disturbed area.

In examining the records over the past two or three years, I have found that at least 75 per cent to 80 per cent of the prisoners sent here for examination have been found to be sane and returned to the jurisdiction of the Court. I should like to present to you, and through you to the Courts and the Justices of the Peace concerned in your county, a plan whereby we could render to you the service necessary and make it a little easier for our ward personnel.

In accordance with Sec. 659 of the Code of Criminal Procedure, upon the request of the Court, the Director of this hospital would appoint two qualified psychiatrists to examine the patient. However, under Section 660, it goes on to state that the examination may be made where the defendant is detained, or he may be brought to the hospital, depending on the recommendations of the Director or the psychiatrists who might examine him. I do not mean to be presumptuous in quoting the law, as no doubt you are better qualified than I am in this respect, but I should like to bring out the point that if we were notified ahead of time, the prisoner

could be brought to the hospital by appointment and a preliminary examination, or a final examination, could be done at that particular time, if it were possible to make a complete decision. If the man were found to be sane, he could be returned immediately with the deputies who brought him. On the other hand, if he were out and out psychotic, we would keep him here. If there was any question as to what should be done and still the man appeared sane, he could still be returned to the jail and after our social workers gathered the information, either from the probation officers or the courts or the relatives concerned, we could then see the prisoner again. This would mean that the man would be detained in jail at maximum security rather than at the hospital for 10, 15 or 20 days, a place of minimum security. I feel that if this plan were allowed to work you would find that satisfactory examinations and opinions would be rendered to the Court and it might even work out better than the present plan. In some of the other State hospitals where this plan is in effect, it has worked very well.

The counties are charged $140 a month for the maintenance of these prisoners in the hospital. This money could be saved by the counties if the person concerned was brought by appointment and seen at the hospital. Even if he had to be brought back on two separate occasions and he was not hospitalized, the $140 a month would not have to be paid.

I would welcome any suggestions from you in this matter. I hope that you will be able to pass on the information, as I do not have all the lists of the Courts and Justices of the Peace in each county available to me.

I should like to again assure you of my cooperation and the cooperation of this hospital at any time, but we should like to take care of these legal problems without disturbing our wards and other patients as in the past.

In spite of all precautions, however, 32 patients slipped into the hospital between Jaunary 28, 1959 and December 31, 1959 under Sections 658 or 872 of the Code of Criminal Procedure. These patients were usually brought in late in the afternoon or on a week-end and they were brought from areas where for some reason the authorities had not been reached with the letter. The patients were admitted in many cases by new resident physicians who were not fully acquainted with all the regulations and customs of the hospital. There were many times when it was embarrassing to find somebody who had been admitted on a Saturday, had gone to church on Sunday and on Monday was over at the community store having coffee, or was out for a walk with little or

no supervision, and yet the hospital was supposed to be responsible for his security to the court.

The 32 cases occurring have been divided into three classifications depending on their final diagnoses (Table 1).

In one case, and only one, that listed under the charge of murder, did the hospital ask for deputy sheriffs to watch the patient. There-

Table 1.

1-A Without mental disorder—charged with the following:	
a. Violation of parole	1
b. Vagrancy	1
c. Assault, 3d degree	4
d. Assault, 2d degree	1
e. Disorderly conduct	2
f. Fraudulently secreting personal property	1
g. Public intoxication	4
h. Contempt of court—nonsupport of wife	1
i. Grand larceny, 1st degree Burglary, 3d degree	1
j. Driving while intoxicated	1
k. Petit larceny	1
1-B Psychiatric diagnosis—without mental disorder	
a. Mental deficiency	3
b. Egocentric personality	1
c. Alcoholism	4
d. Schizoid neurotic traits	2
e. Psychopathic personality	4
f. Epilepsy	1
g. Neurotic traits	3
2-A Psychotic or related states—charged with the following:	
a. Public intoxication	2
b. Assault, 3d degree	2
c. Driving while intoxicated	1
d. Disorderly conduct	2
e. Truancy and juvenile delinquency	1
f. Kidnaping	1
g. Murder	1
h. Exposure of person	2
2-B Psychiatric diagnosis—psychotic or related states	
a. Schizophrenia, catatonic	1
b. Manic-depressive psychosis, manic	1
c. Primary behavior disorder	2
d. Schizophrenia, paranoid	2
e. Psychosis with psychopathic personality	1
f. Psychosis due to alcohol, delirium tremens	1
g. Schizophrenia, simple	1
h. Schizophrenia, unclassified	1
i. Schizophrenia, hebephrenic	1
j. Psychosis due to alcohol, pathological intoxication	1

Table 1. (concluded)

3-A Psychoneurosis—Charged with the following:	
a. Public intoxication	1
b. Grand larceny	1
3-B Psychiatric diagnosis—psychoneurosis	
a. Psychoneurosis, mixed	2

fore, this particular case is not illustrative of the criminal order patient in an open hospital. Of the other 31 cases, 26 were eventually discharged and returned to the court. The shortest interval in the hospital was one day, and the longest 41 days, the average (mean) stay was 10.8 days in the hospital. Five patients remained in the hospital, and their status changed from criminal order to regular certification in four instances and a minor voluntary admission in the fifth. Again, in this second group, the shortest stay in the hospital before changing to a different admission procedure was two days and the longest was 31 days. The average stay in the hospital of these five patients before the change of status was 18 days. The individual courses of the 31 patients considered here are shown in Table 2.

Table 2. Records of 31 Criminal Order Patients in an Open Hospital

Group	Date of Admission	Date of Release	Mental Diagnosis	Charge*
3	1-28-59	2-18-59	Psychoneurosis, mixed	Public intoxication
2	2- 9-59 Cert. 3-7-59	7- 1-59	Schizophrenia, catatonic	Disorderly conduct
1	2-16-59	2-20-59	Without mental disorder, other non-psychotic diseases or conditions, character neurosis	Violation of probation
1	3-13-59	4-23-59	Without mental disorder, mental deficiency	Vagrancy
1	4-16-59	4-24-59	Without mental disorder, egocentric personality	Assault, 3d degree
2	5- 7-59 Cert. 5-9-59	Conv. care. 8-29-59	Manic-depressive, manic	Disorderly conduct
2	5- 1-59 Minor vol. 5-22-59	Conv. care 10-15-59	Primary behavior disorder, conduct disturbance	Truancy and juvenile delinquency
1	5- 8-59	5-14-59	Without mental disorder, alcoholism	Assault, 3d degree
1	5- 9-59	5-15-59	Without mental disorder, alcoholism	Assault, 2d degree

*Patient charged with murder was under guard and not included here.

Table 2. Records of 31 Criminal Order Patients in an Open Hospital (concluded)

Group	Date of Admission	Date of Release	Mental Diagnosis	Charge*
1	5-24-59	5-29-59	Without mental disorder, schizoid neurotic traits	Disorderly conduct
2	6-10-59	6-18-59	Schizophrenia, paranoid type	Kidnaping
1	6-10-59	6-24-59	Without mental disorder, psychopathic personality	Fraudulently secreting personal property
1	6-15-59	6-20-59	Without mental disorder schizoid personality and alcoholism	Public intoxication
1	6-22-59	6-23-59	Without mental disorder, psychopathic personality	Contempt of court (Nonsupport)
2	6-23-59	6-26-59	Schizophrenia, paranoid type	Assault, 3d degree
2	7-15-59 Cert. 8-15-59	Conv. care 10-15-59	Schizophrenia, hebephrenic type	Exposure of person
2	7-16-59	7-17-59	Psychosis due to alcohol, pathologic intoxication	Exposure of person
1	7-21-59	7-23-59	Without mental disorder, alcoholism	Public intoxication
1	7-30-59	8-18-59	Without mental disorder, epilepsy	Public intoxication
2	8- 5-59 Cert. 8-15-59	Conv. care 9-27-59	Schizophrenia, simple type	Public intoxication
2	8- 9-59	8-21-59	Psychosis with psychopathic personality	Assault, 3d degree
1	8-11-59	8-14-59	Without mental disorder, mental deficiency	Public intoxication
1	8-14-59	8-18-59	Without mental disorder, psychopathic personality	Assault, 3d degree
1	8-17-59	8-21-59	Without mental disorder, acute alcoholism	Assault, 3d degree
1	8-20-59	8-21 59	Without mental disorder, neurotic traits	Disorderly conduct
2	9- 5-59	10- 4-59	Primary behavior disorder, simple adult maladjustment	Driving while intoxicated
2	9-12-59	9-21-59	Psychosis due to alcohol, delirium tremens	Public intoxication
1	9-22-59	9-25-59	Without mental disorder, other nonpsychotic diseases or conditions. Schizoid and psychopathic traits without psychosis	Grand larceny, 1st degree. Burglary, 3d degree
2	10- 5-59	10- 7-59	Schizophrenia, unclassified	Murder
1	11- 2-59	11-13-59	Without mental disorder, neurotic traits	Driving while intoxicated
3	12-21-59	1-11-60	Psychoneurosis, mixed	Grand larceny
1	12-21-59	1-11-60	Mental deficiency — on convalescent care from Rome State School	Petit larceny

*Patient charged with murder was under guard and not included here.

The point that the writer wishes to emphasize in the discussion of criminal order cases is that, in spite of the fact that these 31 patients stayed between one and 41 days, averaging almost 11 days in the hospital, with no special precautions having been taken, not one made any attempt to escape. It is true that once their status was known, some effort was made at supervision, but they were still kept on an open ward, and they still were allowed to go to church or the community store or to other parts of the grounds—most of the time with little or no supervision. The point is, therefore, made that St. Lawrence State Hospital has admitted patients on criminal order procedure and that during the entire year of 1959 no difficulties were encountered despite minimum security measures and the fact that the patients were on an open ward or in a dining room where the doors were open or were living in areas where there were no bars on the windows.

To leave the discussion of criminal order patients and return to the general subject of the open door hospital, patients in general seem to develop a pride in the hospital and in their wards under the new regime, and they are often anxious to tell visitors all about the hospital happenings and all about their own activities. Some patients like to brag about what they used to be like and how they have changed. They will tell how they used to hide knives, forks and spoons, steal scissors, and try to run away from the hospital, and say that this was their way of creating a little excitement. What was thought to be a move toward suicide because a patient stole scissors, or what was thought to be an attempt to escape proved in reality, not psychotic episodes at all but attention-gaining devices on the part of patients who were trying to break the unrelieved and painful monotony of looking at four walls. Or perhaps the patients were being spiteful and vengeful in an effort to retaliate for what some doctor, or nurse or attendant might have said or done to a patient who then considered he was being punished or being arbitrarily deprived of privileges.

A word should be said in regard to the personnel. The personnel of St. Lawrence State Hospital at first had a healthy apprehension about this new type of care. Being reassured that the director was the one who took the responsibility—which was proved after some incidents occurred, and they saw he was going to take it—their apprehension disappeared. They then tried to work out all sorts of plans to open the doors of their wards and keep them

opened. The principal apprehension on the part of the personnel was really a normal one. They did not want to be reprimanded, as they had been in the past, nor did they want to be fired if anything happened which they felt was not their fault. When fear of such things was overcome, the program progressed more smoothly and rapidly.

The further the hospital goes with this open door program, the more it is found that changes must take place in each department program, in addition to the changes in the physical atmosphere of the hospital. The morale of the personnel is increased when they work in a better, more relaxed atmosphere with less tension and without the yelling and screaming and expression of delusions in which they had worked previously. The program must keep changing and cannot remain a static one. The patients must be regarded as adults and not as children. They must be regarded as personalities and as persons who can assume responsibility in various degrees and must be allowed to, or helped to, take on responsibilities.

Frequently, the writer has been asked whether there was a program to indoctrinate all of the personnel with the philosophy and management of an open ward and consequently an open hospital. At first, of course, there was none, for the simple reason that the administration did not know of the problems that had to be talked about. All that could be done was open the door and then wait and see what would happen. As the administrators learned, from one ward to another, the information was passed on to more of the personnel, as their wards were opened.

The whole philosophy of the psychiatric nurse had to change. From a custodial individual—in most cases with a lock and key and burdened down with counting patients and administration—she had to revert to the psychiatric nursing for which she had been originally trained. If one considers a patient in general medicine or surgery, one finds that early ambulation is necessary in that keeping splints on the patient in bed or at continued rest is a thing of the past. Obstetric patients are out of bed almost the day following delivery. Surgical patients are out of bed and allowed to sit up as soon as possible. In the psychiatric hospital the patient was restricted or "splinted" by being kept on a locked ward much as the hernia patient had to stay in bed for 21 days— except that the psychiatric patients were restricted for weeks, months

and years. As the doors are opened, one finds that the "*bed*-side nurse" has to change to a "*patient*-side nurse." As the patient was allowed outside, the nurse in turn had to be with the patient. The mistake that was corrected very quickly was the idea that if the patient went out, the nurse or attendant had to stay on the ward, that otherwise the procedure would not be legal. However, if the nurse goes out, not as a guard or custodial agent, but as an individual who is going to talk to the patients or engage in some kind of sport, or if she goes to church as a matter of her own choice and talks to the patient on the way, this is "patient-side" nursing rather than custodial nursing. (In this day and age, when space medicine is gaining such momentum, there is no doubt that, if the conquest of outer space should go on, the medical team of doctor and nurse will also have to follow along and do "patient-side" nursing in orbit.)

It is a very expensive proposition to construct new buildings because of overcrowding. The open door program has allowed the staff to judge the behavior of many patients who had been confined for years because it was thought they were dangerous and could not get along. It was found that the open hospital is like a "half-way" house in that one can judge how patients react to freedom and little, if any, restriction. After opening the doors, it was possible to build up a family care program for patients who had been in the hospital so long that they had either outlived their relatives and friends or had been out of the family constellation so long that they were almost strangers to their own families. It would have been extremely difficult to place even those who did have families in their own family constellations again; they are now placed in the community, but remain under the supervision of the hospital. With almost 300 patients placed in this program, the overcrowding was relieved; there was more room for those who remained; and the need for a new building disappeared.

The problem of sex in an open door hospital has frequently been referred to. This, indeed, has to be faced. Sex activity among newly-admitted patients causes no difficulty for reasons that will be discussed. The real problem is sex activity among a certain type of schizophrenics whose illnesses are of long duration, and among psychopaths. It is found in these cases, when one examines the pre-psychotic personality, that tendencies toward illicit sex

activity already existed and have persisted through the psychotic episode but are not part of it. Socialization, consisting of men and women walking down the road, going to ball games, movies, or church together, is encouraged. This may go further—to kissing goodnight or holding hands in the evening and "playing cozy." On occasions people have been found actually trying to engage in the sex act. In all such cases, they are patients who have been in the hospital a long time or are psychopaths. Such a thing rarely occurs in newly-admitted patients. Those causing difficulties are persons who in their pre-psychotic periods did not conform to social standards and customs. The only thing that can be done in most of these cases is to find out the hiding places and make them more public. Talking to the offenders results in a great deal of lip service, which they give with a tremendous show of regret and repentance, and then—when the occasion arises—they repeat their performances all over again. However, the writer would like to emphasize that this is not a serious problem. The number of patients who engage in illicit sex is exceedingly small, certainly a smaller percentage than in the general population. They become known quickly, and they can be easily watched and fairly well controlled. The writer would doubt if, in St. Lawrence, there has been difficulty with more than six to 10 persons in the past four years.

Under-achievement is well known to educators. It occurs in individuals with high IQ's, with apparently high capability, but poor motivation to achieve. They do not want to go to high school or college and work very much below their intelligence capacity. Many reasons might be given for this condition—from sheer laziness and indifference to deep-rooted psychological problems. However, in some of these people the right to under-achieve might be classified as one of their inalienable rights of civil liberty; they do what they want, and do not want to do what someone thinks they ought to do. One can now carry this problem into our mental hospitals. Most patients come into the hospital with the expectation that they will achieve the return of mental health. They are desirous of this, but under-achievement has been fostered, promoted, inspired and developed by locking patients in wards and putting bars on the windows. People have been deprived of responsibility, liberty, and dignity; and the hospitals have removed their motivation to get well and increased their illnesses with

superimposed symptoms, because of what those in authority thought patients ought to be doing and because those in authority created an atmosphere entirely foreign to the patient. If one wants to keep patients from under-achieving the goal of returning to mental health and leaving the hospital, further stumbling blocks and deterrents must not be put in their way.

The writer recently came across two words, new to him, which both apply well to the administration of an open door mental hospital. In the past it seemed as if talking to a group of hospital administrators was a seminar in "eschatology" when it really should have been an exercise in "serendipity." "Eschatology," in its theological meaning, is the consideration of the last or final things, as death, resurrection, immortality and the last judgment. The administrators—threatened with the loss of their familiar hospital worlds—would argue, ask questions and present all sorts of ideas in a fashion resembling a free-for-all discussion of eschatology. There is the difference that the clerics think and argue for their beliefs and try to fathom the ultimate future, whereas the hospital administrators were arguing against the open door hospital and presenting only the extreme perils that could be thought of, in order to avoid the open door program. Such remarks as "Pregnancies may occur," "People may get run over," "There will be fights," "People will run away," and many others refer to things that have all occurred in the closed hospital, without exception. Yet the thought that they might occur in an open hospital greatly disturbs many psychiatric hospital administrators. These worriers should have read Horace Walpole's story of the *Three Princes of Serendip.* "Serendipity" is a word adopted into our lives from this story; it has come to mean "the gift of finding valuable or agreeable things which were not sought for." It is this serendipity that those of us who have gone ahead with the open door administration, have experienced. The writer has found that the open door has reinforced the entire therapeutic program and the therapeutic milieu in the hospital from the use of tranquilizers to the number of beauty parlor appointments. The doors were opened to give the patients more freedom, but as the program unfolded, patients were found to be improving, they were better dressed, smells on the wards disappeared, visitors stopped complaining, tension among personnel as well as patients disappeared, occupational therapy attend-

ance increased, more recreation was demanded; and, so on and so on, the flight into serendipity continued.

In conclusion, the writer would say the open door mental hospital is, as the lawyer says, *"res ipsa loquitur"* that is, "The thing speaks for itself." Four little words of great import should be added, "It speaks for itself *if given a chance.*"

The writer thinks the greatest compliment that he has had and the thing which sums up the open door best at St. Lawrence is a remark in answer to a visitor who asked some of the personnel whether they would prefer to go back to the locked door atmosphere. The answer was spontaneous and instantaneous. "As far as we are concerned you would have a hell of a time to lock the doors around here again."

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A REHABILITATION UNIT ON GROUP THERAPY LINES FOR LONG-STAY PATIENTS*

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1. Introduction

The active treatment of long-stay patients in mental hospitals is one of the major problems of psychiatry. A research unit was opened at Park Prewett Hospital, Basingstoke, Hampshire, England, in the middle of 1955, with the aid of a grant from the South West Metropolitan Regional Hospital Board, to study the effectiveness of group psychotherapy in the rehabilitation of long-stay patients. An account is given here of the first year's work of the unit and the results of a year's follow-up of patients discharged from the hospital.

a. The Problem

Some general comments on the problem of the long-stay patient were made by Bleuler in 1911[1] in his monograph on *The Group of Schizophrenias.* He wrote, "The institution as such does not cure the disease and it carries with it the danger that the patient may become too estranged from normal life and also that the relatives get accustomed to the idea of the institution. For this reason, it is often extremely difficult to place even a greatly improved patient outside the institution, after he has been hospitalized for a number of years. In general, it is preferable to treat these patients under their usual conditions and within their habitual surroundings. Release from the hospital follows the same principles. One should not wait for a 'cure' and one can consider it an established rule that earlier release produces better results. One must also consider the quality of the patient's relatives, they may as easily ruin the patient as they may continue his education. The general tasks of treatment consist in educating the patient in re-establishing his contact with reality. Many patients can be taught to suppress their agitation, to pay less attention to their hallucinations and not to become upset by them, and to give up asocial habits." Bleuler recognizes the adverse effects of institutionalization, the difficulties of returning the patient to his

*This paper is from Park Prewett Hospital, Basingstoke, Hampshire, England. It forms part of a thesis accepted for the degree of M.D. at Cambridge University, England.

relatives and his employers and the need for treatment by re-education.

In recent years, Bickford[2] has revived the question of the forgotten patient. "Psychiatrists have failed to cure and discharge their patients. The business of a hospital is to cure patients, not to hoard them, and the sheltering of patients in hospital without continual efforts to make them fit to return to the world is a complete denial of the function of medicine. Certain hospitals which are so respected with unlocked wards, busy occupational therapists and nondesignated villas should be reexamined by seeking out wards one has not been invited to visit. There most of the patients may never leave the ward, many are in small rooms alone and they are clad in shapeless garments familiar to us all." The point that administrative changes or alterations of nomenclature may be mistaken for active treatment is an important one and is emphasized in one of Bickford's later articles.[3] "The danger that arises when open doors and voluntary status become the order of the day is that they may be accepted as an alternative to actually treating the patients. If he is not treated, a schizophrenic patient whose illness is of long-standing can deteriorate in an open ward as much as in a closed one. The policy of the open door makes it, if anything, easier to avoid necessary action." Rehabilitation can only start when one ceases to regard the long-stay patient as chronic and considers each individual as a potential candidate for discharge from the hospital. This attitude has to be consciously fostered because the atmosphere of the mental hospital tends toward institutionalization.

Martin[4] has considered this problem of institutionalization. "For the patient, there are the factors outside hospital such as inadequate personality and lack of satisfying interests and relationships and unfavourable economic circumstances probably add their weight. Entry into hospital at once removes many of the patient's anxieties and many patients, particularly neurotics, feel much better soon after admission. Once in hospital, the patient quickly becomes absorbed into its highly organised life which tends to relieve him of the need to think or plan for himself in any but the most unimportant trifles. The occupational regime also plays a part in institutionalisation and the productivity of the department becomes more important to the hospital than the effect that the work is having on the patient. The patient is inhibited

from criticism of the staff or the organisation of the hospital lest he be transferred to the refractory ward about which he has frightening fantasies. The doctor is responsible for anything from one to three hundred patients and the tendency of the organisation to produce well-institutionalised patients simplifies his task." Therefore, in rehabilitation, it is necessary to reverse the long-established attitudes of both staff and patients and a technique must be adopted which will stimulate the patients to criticism, activity and even un-co-operative behavior.

Mayer-Gross, Slater and Roth[5] emphasize the value of group activities in preventing withdrawal and deterioration of the long-stay patient. "The type of occupation practiced for therapeutic purposes in English-speaking countries has been more that of pastimes and hobbies than of rough manual work, as on the European continent. There is an unreality about the making of knick-knacks which does not help the schizophrenic to get back to ordinary ways of life. Furthermore, work in groups is desirable on many grounds, and is best combined with work of objective benefit to the community. The patient's inclusion in a group of workers combats his tendency to withdrawal, mitigates his negativism and gives him an opportunity to overcome his other morbid tendencies. These aims are not achieved to the same extent if the patient works on a loom on his own or withdraws into a corner with his rug."

However, working at group activities is insufficient by itself to rehabilitate patients, and it carries the danger of making them institutionalized on a higher level. Therefore it was decided to combine group psychotherapy with occupation as a means of giving the patient active treatment and enabling the staff to understand his individual problems. Some of the techniques of group therapy will now be considered with the suitability of their application to long-stay patients in a mental hospital.

b. Techniques of Group Psychotherapy

Group psychotherapy as a formal treatment of psychiatric patients is fundamentally a product of the twentieth century. Moreno started using it in 1910, and coined the term for it in 1931, giving the new method its formal name. He sets forth some of the principles of this treatment in *Psychodrama.*[6] "In psychoanalysis, the idea of a specific individual organism as the locus of psychic ailment obtained its most triumphant confirmation. Although during

the first quarter of our century, there was occasional disapproval of this exclusive, individualistic point of view, it was more silent than vocal. The decisive turn came with the development of sociometric methodology. This revolutionalized the agent of therapy, who had usually been a single person, a doctor, a healer. Faith in him, rapport (Mesmer), transference (Freud) towards him is usually considered as indispensible to the patient-physician relationship. But sociometric methods have radically changed this situation. In a particular group, a subject may be used as an instrument to diagnose and as a therapeutic agent to treat other subjects." Moreno then discusses the basic categories of group psychotherapy. The constitution of the group may be amorphous or structured and the locus of the group situational, as in the home and workshop, or derivative, as in the clinic. The aim of treatment may be causal and directed toward situations arising between group members or it may be symptomatic, treating each individual as a separate unit. It may be therapist-centered or group-centered and it may be spontaneous or rehearsed, as with formal lectures.

Klapman[7] favors the therapist-centered technique for psychotic patients. "Institutions for mental patients should be considered schools rather than hospitals. The mental patient should be regarded not as a patient but as a student. One should thus approach him with an intent to reeducate rather than with an attempt to treat. It seems reasonable that correction of deficiencies in social attitudes is best accomplished in a social setting. Didactic group psychotherapy is group therapy administered through a textbook or script of systematic lectures. The text serves as the counterpart of interpretation as the latter is given in the individual psychoanalytic sessions." Klapman then gives a list of 20 lectures and discusses other forms of didactic group therapy, such as the reading of case histories or autobiographies, and the conducting of symposia, debates and psychodrama. However, there are major drawbacks in didactic group therapy for long-stay patients. It encourages the patient to continue in his passive role and encourages the staff to maintain the initiative, and it fails to stimulate the patient to be constructive and take full responsibility. In the setting of a lecture, withdrawn patients can sit back and cut themselves off from the proceedings.

Standish[8] describes some of the difficulties of group therapy with psychotics. He held meetings, lasting an hour, two to three times

a week, with groups of 10 to 15 patients. His technique was to participate in the casual conversation of the patients and interpose appropriate comments. He found a common tendency for therapists to do things for the patients and to concentrate their efforts on a favorite patient, particularly in chronic groups where there were silent members. Increasing regression of the favored patient was common if the therapist did not alleviate the situation by attempting to promote greater interaction. He goes on to say: "Psychotic behavior is often the response to a situation in which the patient is unable to make simple but vital decisions. The group is a stimulant for further constructive effort on the part of the patient. The therapist, we feel, can in general restrain himself from interfering except when forces arise that tend to disintegrate the group and prevent it from working towards its goal. They can be resolved usually by helping the patient verbalize the issues involved." One is in agreement with this approach as it encourages the psychotic patient to show initiative and discourages excessive dependence on the hospital staff. Kline and Dreyfus[9] also found the didactic, lecture approach to be ineffective because of a too superficial contact. They used an active, directional group technique for psychotics. Practical problems were worked out, insight was achieved by recognizing similar problems in others, group socialization was used to censure atypical behavior and relieve isolation and hostility, and emotional problems were ventilated. They found group therapy led to a shorter duration of hospitalization in recent admissions.

As the long-stay patient has become accustomed to leaving decisions about work, leisure, treatment and interpersonal tensions to the staff, a technique of group therapy has been adopted which will reverse this trend by throwing the patient back on himself, forcing him to make decisions and encouraging him to ventilate complaints and criticisms. The aim has been to practise the form of group therapy set out by Foulkes and Anthony[10] in their book on this subject. The members sit in a circle with the analyst. No programs or directions are given so that contributions arise spontaneously from the patients. All communications and relationships are seen as a part of a total field of interaction of the group matrix, and all group members take an active part in the therapeutic process. The modifications necessary in adapting this

technique with neurotics to long-stay psychotic patients will be discussed later.

The most comprehensive use of group therapy for rehabilitating psychiatric patients has been in Maxwell Jones'[11] industrial neurosis unit at Belmont Hospital.* Although this unit treats a different type of patient, the unemployed neurotic, its basic plan has been adopted on the Park Prewett Hospital group therapy ward. The program at Belmont Hospital consists of a community meeting from 9 to 10 a.m., which includes films, psychodrama and lectures. The patients are engaged in work of social value from 10 to 12, and from 2 to 4 p.m. They are then free until 7 in the evening when they attend a two-hour social program, organized by the patient's committee. The patient is not seen for individual psychotherapy after the first week, and absence from groups is discouraged. The group meetings of 16 to 28 patients are held four times a week and last an hour. Because of a smaller staff at Park Prewett it has been possible to hold the group meetings only twice a week but the group size has been kept to a maximum of 12 patients, as withdrawn psychotics would be neglected in larger groups. Psychodrama, films and lectures have not been used, as they tend to encourage passivity. The practice of group therapy with psychotic patients will be considered in the next section.

2. The Unit For Group Psychotherapy of Long-Stay Patients

a. Structure

Park Prewett Hospital contains nearly 1,500 beds and serves a scattered, predominantly rural area which extends from Aldershot to Bournemouth, a distance of about 80 miles. It consists of a main central building and 10 peripheral villas. Two adjacent villas were converted into the group therapy ward. The villa for female patients has 37 beds and the one for male patients 33, giving a mixed ward population of 70 patients. The female villa contains the communal dining room, which is also used for evening social functions. The male villa has two large rooms which are used for the group and community meetings, and one of these rooms also serves as a communal lounge for the ward. The villas are open wards with direct access to the surrounding countryside as the hospital grounds are not walled or fenced in.

*Belmont Hospital, Sutton, Surrey, England.

b. Staff

The medical staff consists of a full-time registrar and an assistant psychiatrist, working part-time on the ward. There are a charge nurse and a staff nurse for the male and female villas, and they work a shift system, which enables them all to be on duty for three hours in the mornings when group meetings are taking place. A full-time occupational therapist is attached to the ward and a psychiatric social worker attends three days a week. A disablement resettlement officer of the Ministry of Labour is present on four days a week.

The success of a group therapy unit depends very much on the character and quality of the nursing staff. Its members should be sufficiently stable to accept criticism without taking it personally, and they should know how to maintain a permissive and nonauthoritarian approach to patients. When the ward was opened, a sister with paranoid traits was unfortunately placed in charge of the female villa, and she soon developed a paranoid schizophrenic illness under the strain of the group regime. A nurse who is not suited to group therapy can put considerable strain on the rest of the staff, and it is essential to have senior nurses who are in sympathy with one another and who can develop an integrated group feeling that will withstand some interpersonal criticism. The doctors, in their turn, must be always ready to support the staff of the ward, if necessary, against the policy of the rest of the hospital, and they should be prepared to take full responsibility, in a consistent manner, for any mistakes that are made.

c. Program

The program of the ward was evolved by trial and error from the basic plan of the industrial rehabilitation unit at Belmont Hospital. Initially, community meetings were held daily, but, in time, it was found that this permitted retarded psychotics to sit back unstimulated. Therefore, the number of small group meetings was increased to prevent this. Two large meetings a week proved adequate for covering topics of communal interest. There are now six groups of up to 12 patients which meet twice a week for about an hour.

This regime leaves 24 hours a week for work activities. These are designed to be of a practical nature and related to employment conditions outside the hospital. It is, therefore, the practice to

place patients in the utility departments of the hospital, such as the stores, laundry, paint shop, engineering department and farm. The group working in the gardens attends a weekly lecture given by the head gardener. The occupational therapist supervises these activities and acts as a liaison officer with the utility departments.

A patients' committee is responsible for arranging social functions on two evenings a week and attendance at these entertainments is considered a part of group therapy. The patients are encouraged to attend hospital functions, such as films and art classes, on the remaining evenings of the week.

A staff meeting is held after the patients' groups, with a conference lasting two hours, on one day a week. The following is a summary of the week's meetings and other activities.

Day	9:00 to 10:00	Work Groups 10:00 to 12:00 / 10:20 to 11:20	1:30 to 4:00
Monday	Community meeting	Groups 5 and 6	Work period
Tuesday	Groups 4 and 6	Groups 1 and 3	Work period
Wednesday	Community meeting	(a) Work period (b) Staff meeting	Work period
Thursday	Groups 4 and 1	Groups 2 and 5	Work period
Friday	Garden lecture Work period	Groups 2 and 3	Work period
Saturday	Free time	Work period	Free time

d. Selection of Patients

A basic criterion for accepting patients for rehabilitation by group therapy was some proven capacity for work without close and constant supervision. Persistently violent behavior and extremely disagreeable personal habits excluded patients. Mutism, deafness and inability to understand English also ruled out group therapy, but retarded patients were accepted if they could converse on occasion. All diagnostic categories were eligible, and flamboyant delusions and hallucinations were not considered any bar to admission. Patients with psychopathic personality were limited to five at any one time because of their tendency to monopolize the attention of the nursing staff at the expense of the psychotics. The age limit was usually kept below 65, because of the practical difficulty of finding employment for persons over this age. Patients with

intelligence quotients between 60 and 80 were accepted if they had adequate grasp of practical affairs, such as the handling of money.

Patients considered for group therapy were expected to have completed all physical treatments and individual psychoanalysis.* Tranquilizers were used on occasion but these patients were excluded from the rehabilitation figures. The duration of hospitalization varied from six months to 42 years, but only those who had been in-patients for longer than two years were considered in the rehabilitation project.

Table 1 shows the diagnoses of the patients accepted for group therapy in 1956. The majority were schizophrenic, the illness which fills most of the long-stay beds of a mental hospital.

Table 1. Diagnostic Categories of Patients on Ward During 1956

	Females		Males		
	Total	Number leucot.*	Total	Number leucot.*	Total
1. Schizophrenia	52	6	47	5	99
(a) Simple	5	0	7	0	12
(b) Catatonic	0	0	1	0	1
(c) Hebephrenic	9	0	11	1	20
(d) Paranoid	32	5	27	4	59
(e) Paraphrenic**	6	1	1	0	7
2. Affective psychosis	6	2	7	0	13
(a) Depressive	4	1	6	0	10
(b) Manic-depressive ..	2	1	1	0	3
3. Psychopaths	5	1	1	0	6
(a) Inadequate	1	0	1	0	2
(b) Aggressive	1	0	0	0	1
(c) With addiction	3	1	0	0	3
4. Anxiety state	0	0	2	1	2
5. Hypochondriasis	2	1	5	1	7
Total	65	10	62	7	127

*The second column under females and males shows the number of patients who had been leucotomized. Thus 6 out of a total of 52 female schizophrenic patients had been treated by leucotomy.

**Schizophrenia in involutional period.

Table 2 shows the age distribution of the patients and reveals that the majority of the schizophrenics, considered suitable for rehabilitation, were aged 30 to 50.

*A part-time psychoanalyst attended the hospital and was able to offer psychoanalytic treatment to a few selected patients referred by other members of the staff.

Table 2. Age Groups of Patients on Ward During 1956

Schizophrenics

Age	under 20	20-30	30-40	40-50	50-60	over 60
Males	0	7	16	15	5	4
Females	0	10	18	16	6	2
Total	0	17	34	31	11	6

Others

Age	under 20	20-30	30-40	40-50	50-60	over 60
Males	1	1	2	4	5	2
Females	1	3	3	3	1	2
Total	2	4	5	7	6	4

Table 3 shows the length of hospitalization. Only patients continuously hospitalized for over two years were considered in the rehabilitation figures, but the ward took patients who had been in the hospital for shorter periods and had completed all physical treatments. Many of these were discharged.

Table 3. Duration of Hospitalization of Patients on Ward During 1956

Schizophrenics

Years in hospital	0-2 yrs.	2-5 yrs.	5-10 yrs.	10-20 yrs.	over 20 yrs.
Males	17	9	7	6	8
Females	15	17	14	4	2
Total	32	26	21	10	10

Others

Years in hospital	0-2 yrs.	2-5 yrs.	5-10 yrs.	10-20 yrs.	over 20 yrs.
Males	4	3	7	1	0
Females	4	8	1	0	0
Total	8	11	8	1	0

e. The Practice of Group Therapy

There is no fixed limit for the length of stay on the group therapy ward, as the rehabilitation of long-stay patients is a slow process. When there is considerable pressure on beds, patients are transferred out of the ward after six months if the prospects of resettlement seem remote, but they are told that they will always be reconsidered at a later date. If there are some signs of improvement, they may be kept on the ward for up to two years, a time when the position is reviewed. The majority of those there two years are then moved to other wards to prevent the

formation of a chronic nucleus. A few are retained if there is still some hope of discharge, or when they can act as stimuli for the rehabilitation of other patients.

Each patient attends two community meetings and two small groups a week. This enables the staff to enter into an active, therapeutic relationship with the patients four days a week, in contrast to some long-stay wards where the doctor may have time to see the patient only at six-month intervals for the completion of the statutory notes.

One community meeting is devoted to problems arising from work in the hospital utility departments. The other meeting covers problems of general interest, questions related to the running of the ward and interpersonal difficulties. The meetings serve the function of promoting ward cohesion, and provide an opportunity for ventilating problems arising between members of the six small groups.

The small groups meet twice a week and contain a maximum of 12 patients. The sex distribution is kept equal as far as is possible. A doctor and a nurse attend each group meeting, and the occupational therapist, psychiatric social worker and disablement resettlement officer sit in on each group once a week. Two of the six groups are reserved for the more intelligent patients, as conversation will occur on two levels if the intelligence range is too wide, and group cohesion will be inhibited. The schizophrenic patients fall into three categories, the retarded, average and over-reactive, and they should be distributed equally among the groups. If more than two outgoing, paranoid patients attend one group, it will disintegrate through the excess of projected hostility. Similarly, one psychopath in a group is a valuable catalyst, but several are merely disrupting. Long-standing neurotics are best placed with psychotics who can still verbalize interpersonal problems. By virtue of their preserved contact with reality, neurotics can help to look after the more retarded psychotics and thereby regain their own confidence. Groups receive stimulation from mixing the older and younger patients. The experience and stability of the older persons act as brakes on the young. The drive of the younger patient, with his more recent contact with the outside world, stimulates the elderly. It is aimed to include patients with similar or interlocking problems in the same groups. Patients with like problems are often antipathetic to one another

and gain insight through their disagreements. Appropriate grouping of older and younger patients can reproduce the interlocking problems of family situations. Groups are, therefore, designed on the basis of intelligence levels, diagnosis, reactivity, age and psychogenic factors.

Prolonged stay in hospital makes all patients dependent and apathetic. The most hostile, complaining patient has an underlying expectation that the institution will make all his decisions and provide for his every need. Conversely, the staff has acquired the attitude of authority, and assumes that patients will be respectful and obedient. This active-passive relationship promotes the smooth running of the hospital and perpetuates itself. In group therapy orientated toward rehabilitation the attitude of the staff must first be reversed. The staff role in group meetings should be as passive as possible and, in general, confined to bringing the more retarded members into the discussion by referring other patients' questions to them. There is a constant temptation for the staff to take over the conduct of the group and once more assume the authoritarian role. This reorientation puts a greater strain on the nurse than on the doctor, because the nurse has had years of training directed toward carrying out orders from above without question. The nurse also spends the whole day in contact with his group of patients and is accustomed to maintaining ward discipline by keeping the upper hand. Therefore, he must re-learn his established pattern of behavior before he can allow patients to make decisions and criticize everyone and everything.

Many nurses can never acquire this change of approach because of their inner anxieties. In contrast, the occupational therapist and psychiatric social worker have not received the same authoritarian training, and they gain by feeling a part of an integrated team when attending group meetings of staff and patients. Their work becomes more meaningful when they are able to see the psychiatric problems at first hand. This also applies to the disablement resettlement officer, as he gets to know the patients and their idiosyncrasies at first hand instead of having to make an assessment from a form received at the "labour exchange." His presence is invaluable as a representative of the outside world to the patients and it encourages them to realize that he is finding jobs for persons like themselves. "Unqualified" staff members

often play a useful part in group therapy. The shorthand typist, attached to the ward, often attends the meetings, and patients sometimes prefer to talk to an outsider who knows nothing about psychiatry and who does not represent the official hospital staff.

Before considering the day-to-day working of the group meetings, one must examine the relationship of a rehabilitation ward to the rest of the hospital. This form of treatment was new to the hospital, and the staff of the group therapy ward met some hostility in the early stages. The other doctors felt rejected at not partaking in the experiment and considered it a criticism of their own capacity for rehabilitating patients. This had the indirect effect of stimulating them to discharge patients from their own long-stay wards. The nurses were accused of having an easy time, as they only had to sit and talk, and resentment was increased when key workers were transferred from other wards. However, once the group therapy ward began to show results, its value was recognized; and other wards chose patients for rehabilitation and felt personally involved when their candidates succeeded in leaving hospital. The practice of giving student nurses a period of training in the ward also helped to integrate it with the rest of the hospital.

The function of the biweekly meetings of the community of 70 patients with the full staff is to promote ward cohesion. At the meeting, the patients elect a committee of up to five male and five female patients, and they appoint a secretary. This committee meets once a week on its own, and the secretary records the minutes, which are read out at the next community meeting with the weekly program of hospital functions. He introduces the new admissions and announces discharges, explaining the nature of their future jobs. The committee arranges evening entertainments and is responsible for making new arrivals acquainted with the ward routine. After the weekly announcements have been completed, the meeting is open for general topics of discussion. One meeting is devoted to work problems, and new arrivals are advised about suitable occupations. The weekly employment record is surveyed, and the community discusses the problems of any patients whose work records are inadequate. The disablement resettlement officer informs the meeting of available jobs and goes into the fears associated with leaving hospital and adjusting to employers and workmates.

The second community meeting is open for free discussion, and the patients are invited to introduce suitable topics. The staff intervenes only when trivialities are dominating the proceedings and leading nowhere. Patients appreciate the opportunity for open criticism, and this gives the staff some insight into the failings of the hospital. At Park Prewett, it soon transpired that certification was the subject of bitter resentment, that it made the patients afraid of the staff and interfered with psychotherapy. As the meetings continued, the patients persuaded the staff to trust them by de-certification, and, at a later date, the ward was converted to nondesignated status as a means of improving relationships. Even the most critical patients stayed on in the hospital after being regraded.

Another frequent complaint was of exploitation. The patients believed they would not be allowed to leave the hospital because they were too useful as workers, and the meetings enabled the staff members to regain these patients' confidence and place them in jobs outside the hospital. A common criticism was of neglect because of lack of medical staff; and a schizophrenic woman explained how she used to smash windows to call attention to her plight in a locked ward. The staff learned that psychotic patients are subjected to much additional suffering when they are imprisoned for long periods. By alleviating this feeling of neglect, group therapy improved conduct and confirmed Stanton and Schwartz' observations[12] that disturbed behavior is sometimes related to inadequate outlets for communication.

The attitude of people outside the hospital toward mental illness was frequently discussed, and patients were apprehensive of meeting prejudice in relatives, acquaintances and employers. The presence of the disablement resettlement officer, in direct contact with employers, helped to alleviate this. The visits of successful ex-patients were also effective in diminishing this fear. The staff learned that psychotic patients are often sensitive about their disability, and the adoption of a permissive atmosphere of acceptance aided in dispelling this. The support of others in the community meetings diminished the inhibiting factor of personal isolation and was an essential step in rehabilitation.

The community meetings were also used for the resolution of interpersonal tensions in the ward. The patients were encouraged to understand the motives behind disturbed behavior and to decide

suitable approaches for dealing with it. Initially they showed some anxiety at being asked to make decisions about ward problems, and complained that the staff was neglecting them and leaving them unprotected by its authority. But, in time, they learned how to deal with their intercurrent problems, and they were left to decide whether a disturbed member should be transferred to another ward. They usually agreed to retain the patient on the ward and discussed means of helping him to make a better adjustment. Sometimes the group setting proved to be more effective than any sedative or tranquilizer. An extremely paranoid woman patient had persistently upset everyone with her callous and aggressive remarks. In a community meeting, several patients impressed on her that her attitude was becoming intolerable. This concerted opposition gave her sufficient insight to modify her behavior, and she eventually left the hospital.

On occasion, the community meetings were curative, as in the case of a 20-year-old girl of diminutive stature. She was a hysterical psychopath who had failed to benefit from tranquilizers and prolonged individual psychoanalysis. She always managed to arouse sympathy by describing her ill treatment at home and playing on her retarded growth. She often picked on innocent remarks made by staff members or patients as an excuse for violent, antisocial behavior. Shortly after entering the ward, she played two groups of patients against one another and managed to disrupt the staff by setting one of the doctors against the nurses, without anyone fully realizing what was happening. The staff tensions were worked out in a staff meeting, and the two opposing groups of patients were then encouraged to express their differences in the community meeting. It then became clear that the girl had manufactured the situation by telling different stories to each faction, and this led to a general criticism of her behavior. This situation recurred once more before the patients learned not to react to her fabrications. This gave her some insight into her character disorder, and she left the hospital to train as a nurse. She completed her course without requiring any further treatment.

Sometimes an accumulation of trivial irritations is more disturbing than a single, major issue, and the meetings provided an opportunity for ventilating these complaints. One meeting dealt solely with the heating of the dining room and the delegation of

patients to lay the fire and clean it out in the evenings. Other domestic matters included ward decoration, diet, times of meals, provision of newspapers and magazines, the use of the radio and clothing. The staff always made a point of reaching a clear decision on these matters, as they could end up by becoming major issues of friction in the ward. Group therapy should include these minor but practical matters in its scope.

Initially the community meetings were held on five days a week. However, with a population of psychotic patients and a slow admission and discharge rate, there were not enough general topics to justify this, and the small group meetings were increased from one to two a week. Attendance is compulsory, but patients may leave before the end if they wish, and motives for leaving are discussed at the next group session. Patients and staff sit in a circle and the staff members make a point of placing themselves between patients, as there is a general tendency for patients to congregate at one side of the group and leave a gap between themselves and the staff. As the group progresses, the positions of the patients are noted, as they serve as a guide to interpersonal tensions. Sometimes a new patient sits outside the group. This situation is treated permissively until the patient has got used to the group, and it is then brought up as a topic for general discussion. Another common reaction to the group is the reading of a newspaper or book during the meeting, and this is treated in a similar manner. It is usually an expression of aggression in neurotics and psychopaths, and a defense mechanism against ideas of reference in schizophrenics. The group meetings generally last for an hour but are extended by as long as half an hour if the discussion warrants it.

The staff aims at taking a minimal part in the group meetings, to encourage initiative in the patients; but this cannot be done to the same extent as with neurotics. A group of neurotics responds to silence with anxiety, and this leads to self-expression. Psychotics, in contrast, can sit mute and apathetic for an hour without showing tension or gaining anything in the process. Therefore, the staff may have to initiate discussion and keep it going. A psychotic has difficulty in developing group feeling, and tends to address his remarks to the staff in preference to other patients. This is met by the staff referring such questions to other members of the group and refraining from giving an answer. In neurotic

groups, a patient who monopolizes the meetings will eventually be checked by the other members and, in this way, draw them out. Psychotics are content to let one patient do all the talking, and the staff has to curb the voluble, stimulate the withdrawn, and guard against taking the line of least resistance, which is the silent encouragement of the extraverted members.

Subjects of discussion at the group meetings include those described in the conduct of the community meetings, but more emphasis is placed on the analysis of the individual patient's illness. Precipitating factors, present symptoms and the particular difficulties which are keeping the patient in the hospital are explored in detail. It is often found that the most disabling symptoms are lack of confidence or problems of a neurotic nature, rather than the psychotic illness in itself; and the value of group therapy in managing these difficulties is illustrated by the following reports on three patients. The first appeared to gain insight through the group setting, the second regained his confidence, and the third resolved her overlying neurotic problems.

The first patient, a single woman, aged 35, suffered from paranoid schizophrenia of five years duration. She believed that her father was the Duke of Windsor and that her mother was Josie Collins,* and she heard voices telling her to get in touch with them. She had traveled around the country as a result of this, and she was admitted to the hospital after asking the police to aid her in her search. She was a talkative, outgoing personality who spent several group meetings describing the search for her parents in considerable detail. This exasperated the other patients who told her she was deluded, and they made a joke of it when she started on her story. At the same time, she discussed her disappointment at her fiancé's death in the last war and her jealousy over her sister's successful marriage. She soon lost her delusions, talked of general topics in the groups, and obtained a job as a shorthand typist. At the time of writing, she has been working for a year and a half. Considering the length of her illness and the small chance of a spontaneous remission, it appeared she had directly benefited from group therapy.

A single man, aged 41, had been an in-patient for 10 years, suffering from paranoid schizophrenia, with delusions that he was the King of Sweden. His illness was in partial remission

*A music hall star.

and he was in good touch with his surroundings. However, he was entirely lacking in confidence and was afraid of leaving the hospital. Frequent contacts with this patient in the group meetings enabled the staff and other patients to understand his fears and encourage him to visit his relatives for week-ends. It required a year before his confidence was sufficiently restored for him to start work. He has been fully employed for a year and has lived in lodgings. There is little doubt that he would have continued to vegetate on a back ward if he had not received intensive treatment by group therapy.

A single woman, aged 48, suffered from paranoid schizophrenia of 16 years duration but had been in the hospital for only a year. Her psychotic symptoms consisted of thought-blocking and impaired concentration, but they were not gross and did not account for her incapacity. Group therapy revealed that her recent problems were more of a neurotic character. A wealthy, elderly man had terminated relations with her after there had been considerable friction between the patient and his daughter. A younger woman patient in the group reminded her of this daughter, and she was able to work out her aggression on this patient and gain some insight into her problem. She had also been rejected at an early age by her dominating mother, and this led to her exclusion from the family circle. Her mother was still alive, and the incompatibility remained, but the patient was unable to accept it. As the groups progressed, she repeated the family situation by antagonizing everyone with her penetrating criticisms, until the other members of the group explained to her what she was doing. She treated the staff in a similar manner but was relieved to find her hostility was accepted without any ill-feeling. She began to realize that she could not alter her own character or that of her mother and, after accepting this, her aggression diminished. Group therapy helped her in her neurotic problems, while the minor psychotic symptoms remained. She left the hospital to study at an art school with the aid of a small private income, and she had not required any further psychiatric treatment in the next 18 months.

Group therapy is incomplete without staff meetings, and these were held for half an hour on four days a week, and for an hour and a half on one day a week, following the patients' meetings. Although informal, they served as a kind of psychotherapy for

the staff, and it was the policy of the doctors to delegate as much responsibility as possible to the nurses and encourage them to make open criticisms and suggestions. In the mental hospital, it is customary for the nurse to report that a patient is a bad influence, a poor worker or un-co-operative. This usually implies that the nurse expects the doctor to transfer the patient to another ward. The nurses were, therefore, encouraged to explore the motives behind the patient's behavior and bring their criticisms up at group meetings, instead of relying on the doctors to make the decision without giving the patient a hearing. Any interpersonal difficulties were brought into the open to prevent staff tensions from disturbing the patients; and it was important to maintain confidence and morale, as the rehabilitation of long-stay patients is a slow process, and immediate, spectacular results are not obtained. The physician superintendent, the matron and the chief male nurse attended one staff meeting a week. This attendance enabled clear-cut decisions to be made on administrative matters and served as a liaison with the rest of the hospital.

It is customary to segregate the sexes on long-stay wards in a mental hospital, and the use of mixed groups and a communal dining and living room was not readily accepted when the ward was started. The staff prophesied trouble and the patients, after years of segregation, were apprehensive at having to meet the opposite sex. However, the introduction of mixed groups stimulated patients to take more interest in their personal appearance, diminished behavior disturbances and modified obscene language. In group meetings, patients were often helped more readily by nursing staff members of the opposite sex, and this led to smoother running of the ward. There were two marriages between discharged patients. They appear to have been successful and have contributed to their rehabilitation. Only two patients have needed to be moved from the ward because of their sexual activities.

Group psychotherapy has converted the ward into an active treatment unit. It has enabled the staff to have daily therapeutic contact with the patients, and it has given the patients a goal in life. It has shown that schizophrenics can develop a communal feeling and re-establish interpersonal relations when given the opportunity. The results of the first year's work of the ward will now be discussed.

3. The Results of Group Psychotherapy

a. Definition of Rehabilitation

The aim of the research project was to determine the effectiveness of group psychotherapy in the rehabilitation of long-stay patients. Therefore any patient who received intensive individual psychoanalysis, sedatives, tranquilizers, deep insulin therapy, electric convulsive therapy or leucotomy during the year prior to discharge was excluded from the results. A long-stay patient was defined as one who had been continuously in the hospital for over two years, as spontaneous remissions in schizophrenia are uncommon after this period.

A patient was considered fully rehabilitated if he was entirely self-supporting for a year after discharge from the hospital and had not required further medical treatment. A married woman was considered fully rehabilitated if she took complete responsibility for the running of her home for a year after leaving the hospital. Therefore, all unemployed patients and all patients living in the hospital and going out to work locally were excluded from the results.

The discharge rate of patients continuously hospitalized for over two years in the four years before the opening of the group therapy ward was used as the control. The same definition of full rehabilitation was applied to these patients.

b. Rehabilitation Results

Table 4 shows the number of patients fully rehabilitated after a year's follow-up during the years 1951 to 1954. The group therapy ward started in the middle of 1955, and this year has therefore been excluded.

Table 4.

Year	Fully Rehabilitated Patients		
	Males	Females	Total
1951	1	2	3
1952	2	4	6
1953	3	2	5
1954	2	4	6
Average (mean) for 1951-1954	2	3	5

Table 5 shows the number of patients fully rehabilitated from the group therapy ward and other wards after a year's follow-up during the year of 1956.

Table 5.

Ward	Fully Rehabilitated Patients Males	Females	Total
Group therapy ward	7	4	11
Other wards	2	0	2
Totals for 1956	9	4	13

The rehabilitation figures increased from a mean total of five for the years 1951 to 1954 to a total of 13 for the year 1956. The hospital population, excluding annexes for patients with senile dementia, was lower in 1956 than from 1952 to 1954, as is shown in Table 6.

Table 6.

Year	Males	Females	Total
1951	643	720	1363
1952	657	761	1418
1953	663	772	1435
1954	671	793	1464
1956	598	811	1409

Table 7 summarizes the case histories of the 11 patients who were fully rehabilitated by group therapy in 1956. For schizophrenics, the mean age at discharge was 51, and the mean length of hospitalization was 19 years. For patients in other diagnostic categories, the mean age at discharge was also 51 but the mean length of hospitalization was three years.

Table 7.

No.	Age	M/S	Diagnosis	Yrs. in Hospital	Occupation Previous	Present	Accommodation
1.	58	S.	Paranoid schizophrenia	23	Marine engineer	Cleaner	In lodgings
2.	50	S.	Paranoid schizophrenia	23	Laborer	Caretaker	With sister
3.	56	S.	Paranoid schizophrenia	29	Bank clerk	Laborer	Living-in job
4.	65	S.	Paranoid schizophrenia	17	Servant	Servant	Living-in job
5.	40	S.	Paranoid schizophrenia	19	Draper	Laborer	With parents

Table 7. (concluded)

No.	Age	M/S	Diagnosis	Yrs. in Hospital	Occupation		Accom-modation
					Previous	Present	
6.*	38	S.	Paranoid schizophrenia	3	Domestic	Factory	Lodgings
7.	35	M.	Anxiety state	3	Laborer	Laborer	With wife
8.	55	S.	Hypochondriasis	2¾	Farmer	Gardener	Living-in job
9.*	61	S.	Hypochondriasis	2½	Private means		In hotel
10.*	72	M.	Late involutional depression	4	Housewife		At home
11.*	30	M.	Inadequate psychopath	2½	Domestic	Domestic	Living-in job

*Female patients. Age is that at discharge. Previous occupation refers to last job before admission to hospital. M/S is married or single.

c. Discussion

The ward for intensive group therapy of long-stay patients has resulted in the rehabilitation from the hospital of 13 patients in 1956, compared with a mean of five patients in previous years. There has been no significant change in the total hospital population or the staffing of the hospital during these years, and, therefore, it may be concluded that the ward has been responsible for the results and that the research project has been a success. The introduction of tranquilizers has not been the cause of the improvement, as patients receiving these drugs have been excluded from the results.

Certain points of interest emerge. The rehabilitation rate for women has not altered. The probable explanation for this is that a female patient is more likely to leave the hospital in the early stages of her illness, as she can be supported by her relatives while the male patient must be well enough to earn a living. This leaves a residue of severely incapacitated female patients in the hospital. It is unlikely that women are more prone to institutionalization, as men usually find it easier to live in communities. There was never any shortage of available jobs for women.

Five of the six rehabilitated schizophrenic patients had been in the hospital for over 15 years. It appears that the severe forms of schizophrenia take at least 10 years to stabilize sufficiently for the patient to ignore his symptoms. Carstairs,[13] in his investigation of post-hospital adjustment of chronic mental patients,

found that schizophrenics with a longer stay in hospital had slightly superior outcomes. The rehabilitated patients all suffered from the paranoid form of schizophrenia. This, the writer believes, is because it disrupts the total personality less than the simple, hebephrenic and catatonic forms. The rehabilitated, nonschizophrenic patients had all been in hospital under four years. The few who were not rehabilitated suffered either from severe drug addiction with psychopathic personality or from manic-depressive psychosis with only short intervals of normality.

The best subjects for rehabilitation were patients who had previously shown some aptitude for work in the hospital and whose contact with their surroundings was reasonably well preserved. In general, the withdrawn or over-reactive patient failed to leave the hospital. Carstairs[13] found that schizophrenic patients returning to relatives were prone to relapse. Two of the six rehabilitated schizophrenics reported here went to live with relatives and no difficulties ensued.

There have been few systematic rehabilitation projects using group therapy as a form of active treatment. Burr[14] describes the employment of group work therapy in Holland, and Carstairs[15] discusses the occupational treatment of chronic psychotics in Holland, Belgium and France, but there is no mention of rehabilitation results. May[16] gives an account of the typical habit-training regime now being used in this country, but the aim is to improve behavior rather than discharge patients, and it tends to produce institutionalization on a higher level than before. In contrast, Baker[17] describes an experimental workshop in a mental hospital orientated toward rehabilitation. The unit employs 40 female patients on the assembly of cardboard boxes and 20 male patients on piece-work from a local car factory. He was able to discharge three patients after four months, but the length of the follow-up is not given. Cameron[18] describes an experiment in which a group of patients and nurses were given an opportunity for developing enduring relationships on a refractory ward. Although behavior improved with this informal group therapy, no patients left hospital.

Stringham[19] gives an account of 33 patients, continuously hospitalized for at least four and a half years, who were discharged from a single ward during a 20-month period. He found the main problems were family opposition, staff inertia, patient in-

ertia, understaffing, overcrowding and the opposition to discharge of good workers. It appears that opposition of the family is a more important factor in the United States than in Great Britain. He overcame patient inertia by repeated interviews but does not give any details of his technique. Although 24 patients remained outside the hospital after two years, only half were self-supporting.

Phillips and May[20] obtained good results from a six-month experiment in rehabilitation. They studied a group of 72 male patients, considered suitable for an open ward with minimal supervision. Voluntary weekly meetings were held with the patients, and the staff also met weekly. Twenty-six patients, who might otherwise have stayed indefinitely, left the hospital, and all but one were economically self-sufficient. The length of follow-up is not stated. A further 29 patients were considered to be no longer receiving any benefit from hospitalization but they do not say what prevented their discharge.

Greenblatt[21] describes a research project of the Boston (Mass.) Psychopathic Hospital for the rehabilitation of the mentally ill. There were weekly ward groups with the nurse to discuss living conditions, and use was made of a transitional day hospital and a social club outside the hospital. The account is in general terms, and results are not mentioned.

Schoenberg and Martin[22] have recently given an account of a male schizophrenic unit at Goodmayes Hospital* for patients under the age of 35. They have mixed recent admissions, receiving deep insulin treatment, with long-stay patients and they have brought the family into the treatment situation. (The attendance of relatives is a valuable innovation but it depends partly on having recent admissions still in contact with their families and partly on having a compact catchment area which makes this practicable.) They avoided rigid habit training and unlimited permissiveness. They did not leave decisions about work to the patients, but they left the leisure hours relatively unorganized as in normal life. Work was always a community project. There was a weekly ward meeting and a patient's committee for arranging rotas of ward work. No follow-up studies are reported. The upper age limit of 35 excludes many older, stabilized schizophrenics, and there are disadvantages in treating recent admissions

*Goodmayes Hospital, Ilford, Essex, England.

and long-stay patients together, as they need different therapeutic approaches.

It is only in recent years, with more adequate staffing and financing of the mental hospitals, that an attempt has been made to treat the long-stay psychiatric patient. An account has been given here of the value of intensive group therapy in meeting this problem of rehabilitation in the mental hospital.

4. Summary

The problem of the rehabilitation of long-stay patients in the mental hospital is considered. It is important that administrative measures such as opening wards and de-designating* patients should not become a substitute for active, psychiatric treatment. The intricate structure of the mental hospital produces an attitude in both patients and the medical, nursing and ancillary staff which encourages institutionalization. The value of group activities in reversing this trend is recognized, but they can also lead to chronicity if not combined with a therapeutic approach orientated toward the outside world. Group therapy provides such a method of active treatment and prevents patients from becoming lost in the occupational departments of the hospital. The different techniques of group therapy are surveyed, and reasons are given for adopting a permissive, nonauthoritarian approach.

An account is given of the setting, structure and staffing of a rehabilitation unit, and the importance of a suitably orientated nursing staff is emphasized. The criteria for selecting patients for group therapy are a proven capacity for work, reasonable social adjustment and some ability to benefit from open discussion of their problems. All diagnostic categories are accepted, but there are reasons for limiting the number of psychopaths. The factors in designing groups are considered. Patients should be of roughly equal intelligence; retarded and over-reactive patients are evenly distributed and older and younger patients are mixed to reproduce family situations. A single group should not contain more than two paranoid or psychopathic patients, because of their disrupting influence. The conduct of the meetings is designed to make patients show initiative and take full responsibility. Subjects of discussion include ward routine, work, interpersonal tensions and the problems of mental illness. Group ther-

*Transferring certified patients to voluntary status.

apy helped to alleviate psychotic symptoms, resolve neurotic difficulties, restore self-confidence and resocialize patients. It should be supplemented by staff meetings to prevent staff tensions from disturbing the patients.

A long-stay patient is defined as one continuously hospitalized for over two years. The results of rehabilitation by group therapy are discussed. Patients receiving physical treatments or intensive individual psychoanalysis in the year prior to discharge are excluded from the results. A patient is only considered fully rehabilitated if economically self-supporting in a job or, in the case of a married woman, running her own home, for a year after leaving the hospital without requiring further psychiatric treatment. After the opening of the rehabilitation unit, the rehabilitation rate increased from a mean of five in the years 1951 to 1954 to 13 in 1956. As there was no significant change in the hospital population for these years, it was concluded that group therapy was responsible for the increased discharge rate. There was no rise in the discharge rate for females and reasons for this are postulated. The factors favoring rehabilitation are discussed, and other rehabilitation projects using group therapy are surveyed.

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References

1. Blueler, E.: Dementia Praecox or The Group of Schizophrenias. (1911.) Translated (1950) by J. Zinken. Pp. 474-479. International Universities Press. New York. 1951.
2. Bickford, J. A. R.: Lancet, 6896: 916-919, 1955.
3. ——: Lancet, 7017: 423-424, 1958.
4. Martin, D. V.: Lancet, 6901, 1188-1190, 1955.

5. Mayer-Gross, W.; Slater, E., and Roth, M.: Clinical Psychiatry. Chapter 6, p. 282. Cassel. London. 1954.
6. Moreno, J. L.: Psychodrama. Vol. I, pp. 315-319. Beacon House. New York. 1946.
7. Klapman, J. W.: Chapter 12. In: The Practice of Group Therapy. S. R. Slavson, editor. Pushkin Press. London. 1947.
8. Standish, C. T., et al.: Am. J. Psychiat., 109: 283-286, 1952.
9. Kline, N. S., and Dreyfus, A.: Am. J. Psychiat., 104:619-622, 1948.
10. Foulkes, S. H.: and Anthony, E. J.: Group Psychotherapy. I, p. 28. Penguin Books. London. 1957.
11. Jones, M.: Social Psychiatry. Chapter 2. Tavistock. London. 1952.
12. Stanton, A. H., and Schwarz, M. S.: The Mental Hospital. Chapter 11, pp. 236-237, 1954. Tavistock. London. 1954.
13. Carstairs, G. M.: Lancet, 7048: 685-689, 1955.
14. Burr, J.: Lancet, 4899: 1083, 1955.
15. Carstairs, G. M.: Lancet, 6898: 1027, 1955.
16. May, A. R.: Lancet, 6921: 500-502, 1956.
17. Baker, A. A.: Lancet, 6911: 278-279, 1956.
18. Cameron, J. L.: Lancet, 6905: 1384-1386, 1955.
19. Stringham, J. A.: Am. J. Psychiat., 108: 924-928, 1952.
20. Phillips, F., and May, S. B.: Am. J. Psychiat., 114:344-350, 1946.
21. Greenblatt, M.: Am. J. Psychiat., 114:619-622, 1958.
22. Schoenberg, E., and Martin, R.: Lancet, 7043: 412-415, 1958.

HUNTINGTON'S CHOREA IN TURKEY*

BY FARUK BAYULKEM, M.D., AND IBRAHIM TUREK, M.D.

In a survey of English-language textbooks, reviewed for possible use in Turkey, the authors came across the speculation that there might be no cases of Huntington's chorea in Turkey.** Statistical data were given for several other countries, indicating various incidences for the disease; and the writers, therefore, inquired into the Turkish situation. They covered all ascertainable cases that had been diagnosed as Huntington's chorea between 1947 and 1959 and are presenting them to the textbook authors for use in their next edition.

The diagnoses, made by several hospitals, were based on five criteria considered characteristic of the disorder: (1) direct heredity, (2) involuntary choreatic movements, (3) progressive course without remissions, (4) progressive psychic disorders, and (5) onset in middle age. All criteria were not met in all patients. The fifth, for example, is of less diagnostic importance than the first three. The medical literature includes instances of the onset of this disease in early life. Stevens presented a case occurring in childhood; Osler had a case of an 18-year-old boy; Hoffman and Peretti cited cases of onset in the early twenties; and Macey reported three patients under the age of 30. One of the present writers has presented the case of a 12-year-old with all the definite symptoms of Huntington's chorea. Bell concluded that of 400 cases reported up to 1934, 10 per cent were under the age of 20. Felstein and Stone reported two patients of less than 17.

Survey

Admissions since 1947 were surveyed for all the Turkish hospitals to which patients with Huntington's chorea might be admitted. The Bakirkoy State Hospital, where both authors were staff members, would receive most of them because of its large number (5,000 annually) of admissions.† The University Hospitals, two small state hospitals, were also sources of data.

*From Bakirkoy State Hospital, Istanbul, Turkey.

**Keschner, Moses: Dyskinesias. Chapter in: Tice's Practice of Medicine. LeRoy Hendrick Sloan, editor (Frederick Tice, original editor). Vol. X, pp. 307-444. W. F. Prior Company, Inc. Hagerstown, Md. 1957.

†Because of administrative policy (which may involve earlier discharges than in the United States) Bakirkoy State Hospital has a proportionately high admission rate, involving many re-admissions.

The Bakirkoy records showed numerous cases since 1947 diagnosed as Huntington's chorea; and the writers analyzed these and other reported cases by comparing with their five criteria. Questionnaires were sent to all Huntington's chorea patients who had been discharged in spite of persistence of illness. Cases manifesting all five criteria were classified as "complete Huntington's chorea"; and those lacking one or two criteria were listed as "Huntington's chorea, not well defined." The inquiries covered heredity, psychic changes, onset, course of the disease, and occurrence of chorea in persons closely related to the patients.

Results

1. Thirty-five cases of Huntington's chorea were recorded between 1947 and 1959 in Turkey. Eighteen were listed as "complete Huntington's chorea," having all five criteria present; 17 were "Huntington's chorea, not well defined," cases that the authors were convinced were of Huntington's chorea, but which lacked one or two of the criteria the writers had set up.

2. Incidence of the disease did not seem to be affected by geography. If Turkey is divided into county districts, the findings for patients on whom the information could be obtained* are:

County	No. of Cases
Marmarian	5
Middle Anatolia	3
Black Sea	5
Aegean	3
Southeast Anatolia	4
Immigrants	4

3. The 35 patients, divided by sex, were 27 males and eight females. The male preponderance agrees with that found by Huntington himself.

4. The ages at which onset of the disease was reported follow.* The mean age of onset was 37, the range from 12 to 57.

*Complete information was not available in all cases. The findings in the following table, and in those under paragraphs 4, 6 and 7 cover the patients for whom the pertinent data were obtainable.

Age of Onset (Years)	No. of Cases
0 -20	2
20-30	4
30-40	9
40-50	10
50-60	4

5. The patients lived a mean of 10 years after onset of the disorder.

6. Where they could be determined, the parts of the body first affected by the involuntary movements of chorea were as follows:

Part of Body	No. of Cases
Face	2
Upper extremities	8
Lower extremities	2

7. The psychiatric symptoms reported were:

Symptom	No. of Cases
Demential syndrome	7
Irritability	4
Mental retardation	3
Poor affect	2
Disorientation	3
Trend toward suicide	1
Psychomotor hyperactivity	2
Insomnia	1

8. Direct heredity was determined in 21 cases, in most of these through the paternal line.

9. The incidence of Huntington's chorea in Turkey compared to other areas was estimated as follows. The figures are for diagnoses of Huntington's chorea out of each 10,000 admissions to general hospitals. They are: England, 6; Germany, 2 to 2.7; state of Michigan, 11 to 24; Turkey, 5.5.

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TRANYLCYPROMINE IN THE OFFICE TREATMENT OF DEPRESSION

BY OSCAR PELZMAN, M.D.

Clinical testing of drugs in private practice is seldom completely objective. The personality of the physician, the way in which the medication is given, and even apparently innocuous statements or actions of the physician, can produce clinical responses that are often attributed to the drug. These limitations are most obvious in the evaluation of drugs used to treat patients with psychoneurotic or psychotic disorders. For such patients there are seldom any strictly objective standards by which progress can be measured. Nevertheless, every physician is, of necessity, constantly evaluating new drugs or methods of treatment. This report is a description of a clinical evaluation of tranylcypromine, (trans-dl-2 phenylcyclopropylamine) a new antidepressant drug that possesses *inhibiting* properties for monoamine oxidase.

During a period of six months 15 male and 22 female patients (average age, 42.7 years; range, 18 to 64) were treated with tranylcypromine. Although it had been intended to use the drug in all types of depression, initial results indicated that it seemed to be most effective in patients with psychoneurotic depressive reactions, and such patients were selected for particular study. Consequently, 30 of the patients in this series had psychoneurotic depressive reactions. The remaining diagnosis included involutional depressive reactions, three patients; manic-depressive reactions, two patients; obsessive-compulsive reaction, one patient; and schizoid personality, one patient. Twenty-eight patients had been experiencing recurrent depressive episodes (from two to 25 years apart), and had been treated during these episodes with psychotherapy, tranquilizers or sedatives. In six of these patients, electric shock therapy had been necessary. No history of previous depressive episodes was reported by the other nine patients.

In all patients, the current episode had persisted for at least two weeks, (range, two weeks to eight months; median, three months), and 30 of them had failed to respond satisfactorily to treatment with tranquilizers or sedatives (prochlorperazine, trifluopromazine, chloral hydrate, phenobarbital) and psychotherapy before treatment with tranylcypromine was begun. Although the clinical

picture varied from patient to patient, a partial list of symptoms would include: guilt feelings, grim facies, pensive attitude, insomnia, anorexia, somatic complaints without organic cause, anxiety, nervousness, inability to concentrate, disinterest, passivity, psychomotor inhibition, fatigue, and morbid—or, in a few of the more severely depressed patients—suicidal thoughts.

At first, high dosages of the drug (60 mg. a day in divided doses) were used, followed by regular weekly reductions of 10 mg. a day until a maintenance level was established for each patient (usually 10 or 20 mg. a day). In one patient, the dosage was increased to 80 mg. a day for one week before starting the reductions. However, when Peterson and McBrayer* reported successful results with lower doses in the treatment of patients with affective depression, it was decided to begin treatment with doses of 30 mg. a day. The last nine patients in the series received this dosage regimen. All patients were treated with tranylcypromine for from two weeks to four months (median, 5.5 weeks). Eight patients, in whom anxiety, tension or nervousness seemed a major part of the symptom complex, continued to receive tranquilizers (prochlorperazine 15 to 30 mg. a day, or perphenazine 8 to 16 mg. a day), or barbiturates, in addition to tranylcypromine. Prochlorperazine, 15 to 30 mg. a day, was added to the treatment regimen of five other patients in whom symptoms of anxiety began to predominate as therapy continued and their depressions diminished. Psychotherapy was continued for all patients throughout the evaluation.

Serum bilirubin and alkaline phosphatase tests were done on nine patients both before and during treatment with tranylcypromine, and both standing and sitting blood pressures were recorded for all patients at each visit.

Results

The results of treatment were evaluated pragmatically. If adding tranylcypromine to the customary regimen caused the patient to respond more rapidly or more completely to therapy, the drug was considered *effective;* if the patient's response was similar to or inferior to what was ordinarily expected, the drug was considered *ineffective.* By this criterion, the drug was *effective* in 30 (81 per cent) of the patients, and *ineffective* in seven (19 per cent).

*Peterson, M. C., and McBrayer, J. W.: Treatment of affective depression with trans-dl-phenylcyclopropylamine hydrochloride: a preliminary report. Am. J. Psychiat., 116:1, 67-8, July 1959.

As mentioned earlier, the drug seemed most *effective* in the treatment of patients with psychoneurotic depressive reactions; the drug was *effective* in 28 of these 30 patients, but was *effective* in only two of the patients in the other diagnostic categories (one patient with an involutional depression, and the patient with a schizoid personality). Of the seven patients in whom the drug seemed *ineffective,* two returned only once for treatment, three have since responded to EST, one has shown a slight response to intensive psychotherapy, and one refuses to follow instructions and finds temporary solace in alcohol. As far as the patients in whom the drug was *effective* were concerned, some indication of improvement was usually apparent within seven to 10 days, and optimum improvement usually occurred within three weeks.

Just as the symptoms of depression often develop insidiously and become noticeable to the patient only when they begin to interfere seriously with his normal functioning (although his friends and family may have been aware of a personality change for some time), the initial signs of improvement developed subtly and gradually and were often apparent to the physician or the patient's family before the patient recognized them. During the early treatment period, while the patient admitted only slight or no change in his condition, his appearance became less grim, he was often more communicative, and seemed less despondent. Reports from his family that he "was much easier to live with," "seemed less withdrawn" or "takes more interest in me and the children" were common.

As improvement continued (and usually by the second visit after treatment with the drug was begun), the patients themselves appreciated the beneficial effects of therapy. They gradually began to realize that some of their seemingly unsolvable problems could be solved, or that the problems were not so important as they had appeared. These patients commented that they were able to sleep and eat better, were able to concentrate on their duties, were rediscovering the pleasures they had previously found in certain activities, and that they simply "felt better all around." In addition to these signs of progress, they were relieved of nonorganic somatic complaints, were more conscious of their personal appearance (clothing, make-up, etc.) and were more cheerful and articulate during their interviews. Although similar results have been achieved with prolonged periods of psychotherapy (with the occa-

sional use of tranquilizers), seldom have these effects been achieved so rapidly without EST.

The following case histories are examples of results that were particularly satisfying or disappointing.

Case 1

A 59-year-old housewife had a psychoneurotic depressive reaction. This patient's first husband died three years after their marriage, and she remained a widow for 22 years. Two years before her treatment she remarried. Her second husband proved to be an alcoholic; and his inconsiderate and abusive behavior, in addition to her natural concern for his welfare, were immediate sources of stress. Although he made several promises to "reform," he refused to participate in any form of therapy. After about a year, during which the patient had become progressively more disconsolate and despairing, she began to experience frequent episodes of insomnia and consulted a physician. Although the physician was able to control the insomnia with sedatives, the patient's mood did not improve, and, as her depression deepened, he began to fear suicide and referred her for psychiatric treatment.

Treatment was begun with 20 mg. of tranylcypromine, three times a day, in addition to the sedative she was taking. She returned for her second appointment after a week. At this time, her outlook seemed better and she reported that she didn't feel as "blue all the time," and was having no trouble getting a good night's sleep. The dosage of tranylcypromine was reduced to 10 mg., t.i.d., and the sedative was discontinued. One week later, since she continued to improve and the insomnia did not recur, the dosage was reduced to 10 mg., twice a day. The drug was discontinued completely the following week.

When she returned for a follow-up visit two weeks later, she was again depressed, and treatment with tranylcypromine was restarted (10 mg., t.i.d.). She again showed improvement, and is currently being satisfactorily maintained on a dosage of 10 to 20 mg. of the drug a day. It is significant that at no time during the treatment period were any changes in her husband's behavior or in the stresses she experiences discovered. In her own words, "I just don't let it get me down the way I used to."

Case 2

A 32-year-old man had a psychoneurotic depressive reaction complicated by extreme tension and irritability. The patient had received intensive psychotherapy elsewhere for about two years with little apparent response. The newer antidepressant drugs were not then available, and little success was achieved with psychotherapy, or/and with various amphetamines and phenothiazines. He did respond, however, to electric-shock treatments and began to show definite improvement and understanding of his psychodynamics. He then suffered a relapse.

By this time, tranylcypromine was available for investigation, and he began treatment with 60 mg. a day. Because he was extremely tense, nervous, and had insomnia, prochlorperazine, 15 mg., b.i.d., and a mild hypnotic at bedtime were prescribed. He had no improvement after a week, and the dosage of tranylcypromine was increased to 80 mg. a day (20 mg., q.i.d.). He began to improve during this second week of treatment with tranylcypromine, and, at the end of the week, the dosage was reduced to 40 mg. a day (10 mg., q.i.d.). He is now being maintained successfully on 10 to 20 mg. a day and is actively participating in the psychotherapeutic process.

Case 3

A 55-year-old man with an involutional depression had a long history ("as long as I can remember") of worrying and exaggerated concern over comparatively trifling matters, and was overmeticulous and conscientious. During the three months preceding his first interview, he had begun to have spells of weeping, periods of complete loss of interest in any activity, and insomnia. He explained that he was sure he was being punished for some past misdeed and wanted to recall the sins of which he was "guilty" so that he could make "atonement." Treatment was begun with 60 mg. of tranylcypromine (20 mg., t.i.d.) and a mild hypnotic to control the insomnia. After a week, since there seemed to be some slight improvement, the dosage was reduced to 40 mg. a day, and it was subsequently reduced to 30 mg. a day. The patient failed to experience any additional improvement and began to regress. Tranylcypromine was discontinued, and the patient has been started on a course of electric shock therapy.

Side Effects

Side effects occurred in nine patients and are listed in the table. As can be seen, none of these was particularly alarming and all were controlled by reducing the medication. In four of the six patients in whom the drug was discontinued because of side effects, it was re-started after a period of five days to a month. In none of these four patients did the side effect reappear. Serum bilirubin and alkaline phosphatase tests showed no evidence of liver damage, changes in blood pressure readings were insignificant, and no clinical evidence of hypotension was seen.

Side Effects Occurring During Treatment with Tranylcypromine

Side Effect (s.e.)	No. of Patients Affected	Daily Dosage at Time of s.e.	Comment
Insomnia	2	60	Eliminated s.e. by taking final daily dose before 4:00 p.m. and reducing dosage to 30 mg. a day.
		60	Drug was discontinued when patient was admitted to hospital for EST.
Stomach ache or upset	2	60	Eliminated s.e. by reducing dosages to 30 mg. a day.
		30	Disappeared spontaneously in three days.
Headache	2*	60	S.e. disappeared when drug was discontinued—re-started drug at lower dosage (30 mg.) with no recurrence of s.e.
		30	S.e. disappeared when drug was discontinued—re-started drug at lower dosage (20 mg.) with no recurrence of s.e.
Dizziness and palpitations	1*	60	S.e. diminished when dosage was reduced to 30 mg. a day—disappeared when drug was discontinued. Re-started drug at 30 mg. a day with no recurrence of s.e.
Diarrhea	1	30	S.e. disappeared when drug was discontinued.
Headache and rash	1*	30	S.e. disappeared when drug was discontinued—re-started drug at same dosage with no recurrence of s.e.

*Blood pressure normal

Summary

During a six-month period, tranylcypromine, a non-hydrazine monoamine oxidase-inhibitor, was used in combination with psychotherapy in the treatment of 37 patients with various types of depression. Thirty patients reponded more rapidly or completely to therapy than is ordinarily expected. Some improvement was usually seen within seven to 10 days, and optimum improvement usually occurred within three weeks.

The results of this study indicate that tranylcypromine is particularly useful in the treatment of patients with psychoneurotic depressive reactions. Although it was apparently less effective in the treatment of other depressive states, the number of patients treated is too small to permit any definite conclusions concerning its value in these areas. Tranylcypromine produced no toxic liver effects or other alarming side reactions in this series of patients, but a clear picture of the drug's safety will not be available until it has received much more extensive use.

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THE HIERARCHICAL METHODOLOGICAL APPROACH TO PSYCHOPHARMACOLOGY*

BY H. AZIMA, M.D.

The discovery of new phrenotropic substances has provided means of controlling or relieving certain mental syndromes. A considerable and ever-increasing body of studies is concerned particularly with the effect of these substances on a relatively large number of patients. After a certain amount of behavioral studies, it seems obligatory to go beyond this level and investigate the effect of drugs on finer psychological happenings, i.e., on the psychodynamic structure. Only with such studies, may one anticipate finding ways of altering the basic personality structure through direct manipulation of psychodynamic states, within the psychotherapeutic or psychoanalytic situation, by pharmacological agents.

It is submitted that in order to fulfill such expectations a methodological pattern should be set up, which can be applied (1) to all drug studies; (2) to considerations of increasingly narrower fields of inquiry, aiming at structural studies (in the dynamic sense) concomitant with drug administration; (3) to adaptability for yielding information about the intangible and incommensurable parts of the personality which are the very core of the mental structure.

To such an approach, the term hierarchical methodology is given, and the aim of the present paper is to outline such a methodology, or rather a way of approaching psychopharmacological studies, the objective of which is the making of both behavioral and psychodynamic explorations. Many of the points made in this outline are not new; but, due to the paucity of integrated papers on methodology in psychopharmacology, it is felt that the presentation of such a paper should be of some interest. It is to be noted that this methodology has actually been applied to psychopharma-

*From McGill University, Department of Psychiatry, Allan Memorial Institute, Montreal. This study was supported in part by National Institute of Mental Health Grant MY-1794 (C1).

cological studies in the last six years, and for every part of it there has been a corresponding study by the author.*

This report will be divided into seven parts: general levels of observation; general modes of drug administration; technical rules of clinical observation; technical rules of psychological testings; phenomenological sectors of observation; dynamic sectors of observation; and essential rules for assessment of change. In the summary, these parts with their ramifications are outlined in table form which can be referred to for a panoramic view of methodology.

I. General Levels of Observation

As in many other areas of research, it is necessary to proceed from general to particular spheres of observation. Through a gradual narrowing of the field of observation, the limits of natural structural lines of the subject under inquiry—in this case, the mind—should be reached. One may suggest that in psychopharmacology three levels of relatively distinct fields of inquiry can be seen, going from overt (observable) to covert (inferrable) manifestations of the mind. These three levels are:

a. First Level

This level of observation concerns itself with the overt clinical, or behavioral events, including manifest symptomatology. The points of note about this level are: (1) Studies at such a level are mainly indicated in trials of new drugs, where a rapid appraisal of the therapeutic efficacy is required. (2) Behavioral rating scales have their usefulness at this level. (3) The number of patients should be relatively high with an optimum of 100. (4) Therapeutic effectiveness is the main goal, and the results are rated according to the degree of improvement (nil, moderate, marked). "Slight" improvements are included in the "nil" category.

Studies at this level have been reported by the author with chlorpromazine, reserpine, promazine, vesprin, mopazine and imipramine."[1-6]

*It should be explicitly stated that other contributions to methodology are intentionally not referred to because the purpose of this presentation is not a general study of psychopharmacological methodology, but a report on the outcome of a six-year study at the Allan Memorial Institute in psychopharmocology and of the author's rather personal approach to this problem.

b. Second Level

The second level of observation concerns itself with detailed accounts of phenomenological (manifest) changes, investigated through clinical interviews, and dynamic (latent) changes investigated through serial psychological testings. The points of note about this level are: (1) Studies at such a level have their main indications with already known drugs, i.e. those upon which first-level studies have been performed. (2) The number of patients should be relatively small, with an optimum of 10, at each period of study. (3) The main goal is the detection of change in the psychodynamic structure (through inference from phenomenological and psychological test data) and is not therapeutic. Studies at this level have been reported by the author with chlorpromazine, reserpine, meprobamate and tofranil.[7-13]

c. Third Level

This level of investigation concerns itself with the covert or latent changes in the psychic structure. The points of note about this level are: (1) Studies at such a level are undertaken with drugs upon which the first and second levels of studies have been performed. (2) The number of patients is small, with an optimum of four at each period of study. (3) The main goal is the detection of change in the psychodynamic structure. (4) The experimental setting is that of an intensive psychotherapeutic or psychoanalytic situation. Studies at this level have been reported by the author with reserpine,[10, 14] imipramine,[15] chlorpromazine.[16]

II. General Modes of Drug Administration

The regime of pharmacotherapy differs according to the level of study as outlined here.

a. First Level

As mentioned, this level of study is indicated for new drugs. It would be desirable to undertake all such studies in a double-blind way. However, in many psychiatric hospitals, the urgency of treatment prevents (practically, morally, etc.) a traditional double-blind method. Patients cannot be subjected to a long-term placebo treatment when this entails considerable psychological and economic suffering. It may also be contended that such double-blind studies are unnecessary for an adequately potent drug. If a drug requires a statistical operation to show that it is

therapeutically effective, it would hardly have adequate potency for therapeutic purposes and for use in the second- and third-level studies. Such potent substances as chlorpromazine and tofranil do not need double-blind studies to show their effectiveness in manic and depressive states respectively. However, to reach a better appraisal of the drug action in the first level the following maneuvers or points of methodology in drug administration at this level can be considered: (1) Substitution of a placebo for the drug may be done shortly after the therapeutic results have became apparent. The reappearance of pre-drug clinical pictures would be evidence of the potency of the drug—which can be resumed at will, without having the disadvantages of a traditional double-blind method. (2) Large numbers of patients can be used. (3) Trial of the same drug can be done with multiple observers in the same setting. It is evident that if all observers obtain the same results, the reliability of the therapeutic effectiveness is high. A most striking example of such a method, which the author has observed, is with tofranil, which gave identical therapeutic results in the hands of 12 therapists with different orientations (five psychoanalysts, five dynamically oriented psychiatrists and two organicists).

To find a way around the traditional double-blind method, but still preserve its reliability, there has been initiated at the Allan Memorial Institute a "pharmacotherapeutic blind ward" or "service." This consists of a ward, or rather a service, where all drug administration is blind, i.e. the members of the service, consisting of a team of about six psychiatrists, one psychologist and two head nurses, have no knowledge of the drug administered to the patient. The distribution of the drug is determined by an independent psychiatrist and a research nurse. In this way, two separate assessments can be made, one being that of multiple observers and the other of double-blind character. We use the term "multi-blind" to designate such a setting.

Two sets of trials should be undertaken at this level of study: "acute" and "chronic."

1. Acute trials consist of a short-term administration of the drug either to acute or chronic psychiatric patients. The optimum period of trial is considered to be one month in an open psychiatric setting and three months in a closed psychiatric setting.

2. Chronic trials consist of long-term administration of the drug either in chronic psychiatric syndromes for therapeutic purposes, or in acute psychiatric syndromes for the prevention of future attacks. The optimum period of trials is considered to be one year.

b. Second Level

Studies at this level are undertaken only with already known drugs. Two kinds of experiments may be set up for these studies: acute and chronic.

1. Acute experiments are undertaken either with moderate or high doses of a given drug. The double-blind method is needed mainly with the moderate dose experiments. With high dosage, any effective drug can be detected through its physiological effects or complications.

In moderate-dose experiments, it is desirable to use a well-known drug as a placebo instead of an inert substance. The writer has used phenobarbital for this purpose. In experiments with one specified drug (single-drug experiments) the pharmacotherapeutic regime will consist of four periods: two no-drug and two drug periods (one for the placebo and one for the drug under investigation), each lasting for four weeks. In the case of drugs with carry-over, e.g., reserpine, it would be desirable to have a free interval between drug and placebo periods. In experiments with several drugs (multiple-drug experiments) additional four-week periods are used for each new substance, with free intervals between if necessary.

It should be noted that, with drugs of specific effect on a mental syndrome, this pharmacotherapeutic regime cannot be instituted because the syndrome disappears under the influence of the drug. It is useless to substitute a placebo for chlorpromazine in a manic patient who has been receiving the latter substance for four weeks. In many instances, the manic period will come into remission by that time. The same holds true for tofranil in depressive states. In these cases, as mentioned previously, the substitution of the placebo is useful only if it is done early—and shortly after the therapeutic response has become manifest. Even in this way, many patients do not show relapses, and continue the remissions which were induced by the drug.

2. "Chronic" experiments may be undertaken with neurotics, but are usually done with chronic schizophrenics. In acute psychopathological states, chronic experiments cannot be undertaken at the second level of study. These experiments should always be double-blind. In single-drug experiments, the pharmacotherapeutic regime should consist of five periods in the following sequence: no drug (three months), placebo or the drug (six months), free interval (two months), drug or placebo (six months), no drug (three months). In multiple-drug experiments, additional six-month drug periods will be added, with two-month free intervals between them. The selection of these time periods is arbitrary and based upon the assumption that these intervals of observation, with the technique of interviewing which will be discussed, should be sufficient for the understanding of a patient's inner world and the drug-induced changes therein.

c. Third Level

Studies at this level are undertaken with drugs already tried at the second level. The kind of experiment set up for these studies can be termed acute in a chronic background. By that, it is meant that the drug is administered to a patient during repeated periods, alternating with a placebo or other drug. The experimental setting is that of intensive psychotherapeutic investigation or psychoanalysis. Studies at this level are always double-blind, the dosage of the drug is always moderate or low, and periods of drug administration should always be of the same length. Ten sessions may be considered an optimum period of drug administration, after which either a placebo or a new drug is substituted for the drug under study.

III. Technical Rules of Clinical Observations

For the sake of uniformity and close adherence to the objectives set at each level of study, certain general rules should be considered:

a. First Level

The following points should be noted: (1) The objective is mainly behavioral observation; therefore, no content analysis of symptoms is undertaken. The disappearance, or decrease, or change in symptomatology is the sole aim. (2) The periods of observation are short, but frequent, during the day. (3) Mild

change in any direction should be disregarded and, in acute cases, attributed to the hospitalization or transference effect. (4) These observations can be made in essentials by a trained research nurse.

b. Second Level

The following points should be noted: (1) The objective is mainly dynamic observations. A content analysis, according to the sectors of phenomenology and dynamics to be mentioned, is the sole aim, regardless of changes in symptomatology. (2) The patient is taken as his own control. (3) He is interviewed from one to three times a week throughout all periods of pharmacotherapy (drug, placebo, no-drug, as described in II). The interview will last from 30 to 50 minutes, during which a sample of free association of the patient is recorded for control observations. (4) To decrease as much as possible the "therapeutic" impact of the interviews and transference effects, interpretation and explanation should be held to a minimum. The patient should only be encouraged to free-associate in order to allow the recording of spontaneous unfolding of psychic processes. (5) To increase the accuracy of observations and to dilute the transference, multiple observers should be introduced into the experimental situation. For this purpose, on occasions, three participant observers (two psychiatrists and one research nurse) and one or two control observers have been used. The latter go over the material obtained from the patient by the participant observers, without interviewing the patient personally. The independent appraisal of all observers is taken into consideration for the general assessment of changes.

c. Third Level

The experimental setting at this level of study is the psychotherapeutic or psychoanalytic situation. For this reason, items 3 and 4 of technical rules for the second level are not applicable here; the length of the interviews becomes 50 minutes, and the patient remains his own control. The important technical rule here is the introduction of control observers whose independent appraisal of data will be taken into consideration for the final assessment of change.

IV. Technical Rules of Psychological Testing*

The objective in this area may be seen as the use of tests as detectors of psychodynamic changes, regardless of their direction. For this reason only projective tests have been used, and, among these, only the Rorschach and figure drawings. For each of these tests the following tentative considerations can be outlined:

Rorschach Administration

(1) This test is performed only on second-level studies. (2) The testing should always be blind, the psychologist being in total ignorance of the design of the experiment. (3) The times of the test and re-test are before, and at the end of, each experimental period. In periods which involve active drug administration, the re-test should be done just before the cessation of the drug, i.e., the point of the anticipated maximal change. (4) The tester should be an experienced psychologist with considerable familiarity with projective tests. The changes in Rorschach re-testings are usually of very subtle nature, requiring a very experienced observer for their detection. It can be stated categorically that the usefulness of projective tests in psychopharmacology is correlated directly with the degree of the psychologist's experience. (5) No testing of the limits should be done. This omission is to minimize the effect of suggestion and obtain spontaneous responses. (6) For the same reason, inquiry should be brief and included in the administration.

Rorschach Scoring. (1) Statistical computation of individual Rorschach determinants can be made, but, due to difficulties in item analysis of the Rorschach, it may be more informative to use: (2) A quantitative cluster approach. By that is meant the division of Rorschach items into clusters, each giving maximal information about four dynamic sectors to be detailed shortly.

Figure Drawings

This test is of considerable value in longitudinal study of changes. There are no particularities of administration except two: serial administration and lack of inquiry. The test is administered weekly throughout the experimental periods in the usual fashion; however, the patient is not asked to associate about the

*The writer is indebted to his wife for this and subsequent sections on psychological tests, and for her conception of the "dynamic cluster approach" in the Rorschach.

test. Omission of association is insisted upon to minimize the suggestion effect and produce spontaneous projected raw material.

V. Phenomenological Sectors of Observation

Three more or less different sectors can be separated in the phenomenological field and the mental content classified accordingly for research purposes. These three areas are used for the dynamic inferences in second- and third-level studies. The separation of these three sectors is relative and will not be discussed in detail because this would require a separate paper on phenomenology.

1. *Organization of Mood.* In this sector four mood states (anxiety, depression, elation and indifference) can be considered. It is contended that the alteration of mood is one of the few useful indices from which inferences about dynamic changes can be made.[17] Alteration of mood has a fundamental value because it indicates a change in the energetics of the mind—an economical shift in the psychoanalytic sense—and a modification, transitory or permanent, of the balance of internal object relations. It is easily reportable by the patients and easily detectable through behavior and mental content. Significant changes brought about by some of the new potent drugs are mainly in the domain of mood, e.g., elation, depression and anxiety. In psychodynamic studies with drugs, subtle changes in mood have to be considered if one wishes to investigate the use of pharmacotherapy in psychotherapy or psychoanalysis.

2. *Organization of Thought.* The form and content of thought are taken into consideration, and, in particular, the rate of speech (acceleration, deceleration), the quality and quantity of associations (continuity, discontinuity), and the self-directedness and other-directedness of associative content. It is thought that considerations of these items are useful especially for psychodynamic inferences about manic-depressive and schizophrenic studies. Organization of thought in its linguistic aspects changes very little —if any—in other instances.

3. *Organization of Imaginaries.* The term imaginaries is used as a translation from the French term "*imaginaire,*" which indicates, in the psychological sense, all those psychic events with a predominence of primary process characteristics (in the psychoanalytic sense). The imaginaries include four different categories,

i.e., fantasies and daydreams, night dreams, hallucinations and delusions. Evidently these events are reported in thought content, and they affect the "organization of thought," but they are categorized under a different heading, because imaginaries imply the predominance of unconscious processes while thought implies that of conscious processes.

VI. Dynamic Sectors of Observation

Three dynamic sectors will be considered, i.e., organization of ego, of drives and of object-relations. Clinically, these sectors are differentiated through inferences derived from the phenomenological sectors of observation and overt behavior. Their division is necessarily arbitrary and is made only for analytic concern and clarity of presentation.

1. *Organization of ego.* An attempt should be made to indicate separately the defensive and the synthetic functions of the ego. The latter function is evaluated through the consideration of total reality-responsivity. This can be accomplished by taking into account (1) organization of thought, i.e., a shift from incomprehensible and paralogical to comprehensible and logical modes of ideation; (2) appropriateness of responses and behavior; (3) self-appraisal; and (4) orientation to the future.

2. *Organization of drives.* Both overt and covert (inferrible) manifestations of libidinal and aggressive drives should be envisaged.

3. *Organization of object-relations.* In this connection, both internal and external object-relations should be evaluated. This dynamic sector is particularly useful in studies of psychotic patients. Points of note are: (1) degree of preoccupation with internal happenings; (2) intensity and other aspects of guilt feelings, which indicate super-ego vicissitudes and are of particular use in manic-depressive states; (3) the experiential state of being in bits and pieces and dissociated, which indicates the degree of splitting—the state of part and whole object-relations—and is of particular use in schizophrenic states. All these items are helpful in the evaluation of changes in the direction of regression or progression.

Dynamic Sectors in the Rorschach

Three sectors, as has been mentioned, are used in the Rorschach, in addition to the organization of mood, because of the latter's cru-

cial importance. To reach a comprehensive assessment of each sector, a cluster approach is used. By that is meant that all the Rorschach determinants likely to give information about each dynamic sector are clustered together to represent sector evaluation. Evidently, as in clinical assessments, there are many which overlap; however, it is contended that such a cluster approach gives the point of maximal change in the psychodynamic structure.

The different clusters are briefly itemized; the details will be presented elsewhere.

1. *Cluster grouping for mood.*

(a) Elation-depression. This cluster includes (1) the use and handling of color; (2) the speed of responses; (3) the tone of content; (4) the number of responses to the last three cards.

(b) Indifference. This mood range falls between the normal and the depressed mood.

(c) Anxiety. This cluster includes (1) the control of anxiety indicators; (2) the recovery or lack of recovery following an anxiety response; and (3) the tone of content.

2. *Cluster grouping for drives.*

The items are categorized under three denominators: oral, anal and genital responses.

3. *Cluster grouping for the ego.*

This area is the most problematic of all groupings and its schematization is very difficult. In general the following points give indication of various defenses used: (1) the total approach to the test; (2) the approach to each card and the different areas therein; (3) the sequence analysis; and (4) the handling of responses evoking stress and the recovery from this.

4. *Cluster grouping for object-relations.*

This includes: (1) the number of M, H, and Hd responses; (2) the quality of M and H responses; (3) the use of animals in human movement or attitudes; (4) the type of movement in M and FM responses; (5) the content of H, Hd and other objects used in human ways; (6) the use of W or dd; (7) the area of human and nonhuman objects; (8) the choice of objects; (9) FC and Fc responses; (10) the numbers of responses to the last three cards; (11) the type of experience balance as defined by ratios of M:C, and FM+M: Fc+C′.

VII. Essential Rule of Assessment of Change

This topic involves one of the most crucial problems in all psychopharmacological, and perhaps psychophysiological, studies, because it touches upon the fundamental question of relationship between a psychological happening and a drug intake: how do we know that a change is related to, or engendered by, a drug? This is a point of methodology calling for considerable attention, particularly at the second and third levels of study.

a. First Level

Here the assessment of gross clinical changes does not differ from that of any medical treatment. Three particular points are mentioned, which can bring reliability into the therapeutic effect and drug intake relationship: (1) comparative pharmacotherapy; (2) repeatability of a given effect; (3) multiple observers' agreement.

b. Second and Third Levels

It is at these levels, where only a small number of patients are observed and where the objective is dynamic change detection and not therapeutic efficiency, that considerable practical and theoretical difficulties arise in event-drug relatedness. At present, from a clinical point of view, statistical verification of data in the psychodynamic field is irrelevant. We have to find new criteria applicable to experimentation with dynamic intangibles of the mind. In addition to the first-level criteria, which may be the pragmatic trilogy of change evaluation, two other criteria are submitted which are considered the theoretical essentials in any psychodynamic study. These are the concept of "emergence" in relation to the observed, and "incomprehensibility" in relation to the observer.

1. *Emergence.* No event during pharmacotherapy can have a relation to the drug intake unless it appears "emergent" in the patient's phenomenal field. An event is emergent when it appears as not continuous with the patient's existence as a whole and with the patient's own appraisal of his existence's continuity. This idea is current in the ever-repeated statement of patients, who experience the relief of a symptom or a side effect. However, the discontinuity does not in itself guarantee the "emergent" quality of an event and hence its drug-relatedness. It requires another quality, which is:

2. *Incomprehensibility.* When an event seems discontinuous also to the observer, it is an incomprehensible event and truly "emergent." However, for an event to be incomprehensible, the observer has to have a thorough knowledge of the patient's inner world, his responsivity and his habitual pattern of object-relations. The more the observer knows about the patient's psychic processes, the less incomprehensible the events will appear to him. At present, in psychodynamic studies, the opinion of such an observer *is* the main indicator of change. For this reason, the problem of counter-transference and the quality (the knowledge and emotion) of the observer should become the essential concern of any psychophysiological research activity. The concepts of emergence and incomprehensibility can be used as natural structural lines of psychopharmacological or physiological concomitancies. Their reliability depends upon the vicissitudes of counter-transference phenomena.

Conclusions and Summary

In the preceding pages, the author has endeavored to outline a methodology which may be useful in setting up systematic avenues of approach to psychopharmacology. No attempt has been made to go into details, because such an effort seems unnecessary and too cumbersome. The objective is to present a method which may gradually narrow down the fields of inquiry from overt (observable) behavior to covert (inferrible) dynamic changes concomitant with a drug intake. The problem of dynamic change was the focus of the presentation. To give a panoramic view of methodology, it is summarized in the following schema:

Schema of the Methodology

I. General Levels of Observation

a) *First Level*: For overt behavioral events:
with new drugs
with large numbers of patients
objective, therapy

b) *Second Level*:
with known drug
with relatively small number of patients
objective, psychodynamic change

c) *Third Level*:
as with second level
experimental setting of psychoanalysis

II. General Modes of Drug Administration

a) *First Level*:
double blind not necessary
placebo substitution in some patients
multiple observers
acute and chronic trials
pharmacotherapeutic blind service, "multi-blind" trials

b) *Second Level*:
double blind necessary
acute single drug experiments (4 periods)
acute multiple drug experiments (5 periods or more)
chronic single drug experiments (5 periods)
chronic multiple drug experiments (6 periods or more)

c) *Third Level*:
double blind necessary
acute experiments (single or multiple drug) in chronic background
experimental setting of psychoanalysis

III. Technical Rules of Clinical Observation

a) *First Level*:
frequent short observations
mild improvement not considered
research nurse

b) *Second Level*:
patient as his own control
interview 1 to 3 times a week
free association, no interpretation
multiple observers

c) *Third Level*:
patient as his own control
psychoanalytic interviews
control observer

IV. Technical Rules of Psychological Testing

a) *Rorschach*:
only at second level
blind testing
test-retest
no testing of limits
inquiry included in administration
quantitative cluster approach

b) *Figure Drawings*:
serial testing
no inquiry

V. Phenomenological Sectors of Observation

1. Organization of mood
2. Organization of thought
3. Organization of imaginaries (fantasy, dreams, hallucinations, delusions)

VI. Dynamic Sectors of Observation

1. Organization of ego
2. Organization of drives
3. Organization of object-relations
4. Dynamic sectors in Rorschach (mood, ego, drives, object-relations)

VII. Essential Rules of Assessment of Change

a) ***First Level***:
comparative pharmacotherapy
repeatability
multiple observers

b) ***Second and Third Levels***:
emergence
incomprehensibility
counter-transference

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REFERENCES

1. Azima, H., and Ogle, W.: Largactil in mental syndromes. Canad. Med. Asso. J., 71:116-121, 1954.
2. Azima, H.; Kent, E., and Cleghorn, R. A.: The effect of rauwolfia alkaloids in mental syndromes. Canad. Med. Asso. J., 73:886-871, 1955.
3. Azima, H., and Durost, H.: Effects of promazine in mental syndromes. Canad. Med. Asso. J., 76:442-445, 1957.
4. ——: Comparison of the effects of promazine and chlorpromazine in mental syndromes. Canad. Med. Asso. J., 77:671-675, 1957.
5. Azima, H.; Durost, H., and Cahn, C.: Mopazine and vesprin, two new phrenotropic substances. Am. J. Psychiat., 114:747, 1958.
6. Azima, H., and Vispo, R. H.: Imipramine: a potent new antidepressant compound. Am. J. Psychiat., 115: 245-246, 1958.
7. Azima, H.: Value of regression induced by chlorpromazine. Presented at International Colloquium on Neuroleptic Drugs. Paris, 1955. Encéphale, 4:972-978, 1956.
8. Azima, H., and Wittkower, E. D.: Anaclitic therapy produced by drugs. The relation of Isakower phenomena to spider phobia. Psychoan. Quart., 26:190-205, 1957.

9. Azima, H.; Cramer-Azima, Fern J., and DeVerteuil, R.: A comparative behavioral and psychodynamic study of the effects of reserpine and raudixin in schizophrenia. In: Monograph on Therapy, Squibb Institute for Medical Research, 2: 10-15, 1956.
10. Azima, H., and Cramer-Azima, Fern J.: The effects of rauwolfia derivatives on psychodynamic structure. Presented at 113th Annual Meeting of American Psychiatric Association, Chicago. 1957. PSYCHIAT. QUART., 33:623-635, October 1959.
11. Azima, H., and Durost, H.: Alteration of schizophrenic dynamic structure concomitant with reserpine administration. Presented at the 14th meeting of Biological Psychiatry Association, San Francisco, May 1958. Grune & Stratton. New York. 1959.
12. Azima, H.; Sangowicz, J.; Spindler, J., and Azima, Fern J.: Psychodynamic alterations concomitant with intensive meprobamate administration. Presented at Eastern Psychiatric Research Association meeting, October 1958. In press, Dis. Nerv. Sys.
13. Azima, H., and Vispo, R. H.: The effects of imipramine on depressive states. A clinical and psychodynamic study. In press, Arch. Neurol. and Psychiat.
14. Azima, H.: The possible dream inducing capacity of the whole root of Rauwolfia serpentina. Canad. Psychiat. Asso. J., 3:47-51, 1958.
15. ——: Psychodynamic alterations concomitant with tofranil administration. Canad. Psychiat. Asso. J., Vol. 4, Special Supplement, 1959.
16. Azima, H., and Sarwer-Foner, G. J.: Psychoanalytic formulations of the effect of drugs in psychopharmacology. Presented at the International Congress on Extrapyramidal System and Neuroleptics. Montreal, 1960. (In press.)
17. Azima, H.: Changes in organization of mood as a therapeutic and research problem in pharmacotherapy. Presented at the Collegium International Neuro-Psychopharmacologicum. First meeting, Rome, September 1958.

THE FEAR OF TRAVELING: A DISCUSSION AND REPORT OF A CASE

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Among the cases commonly encountered in psychiatric practice and in clinic work, the psychiatrist frequently runs across a number of varying psychiatric conditions which manifest, with their other symptoms, a state of regression and, associated with this, panphobic reactions, especially a phobic reaction to travel. For example:

A 62 year-old man seen in consultation, referred from the medical diagnostic clinic of a general hospital,* had suffered the onset of his difficulties 15 years previously while seeing his only son off to war. As the train pulled out of the station he felt "something snap in the stomach"; he became anxious and depressed; and a few days later, while going to work on a subway train, he suddenly felt he was going to faint and die. After this, his wife had to accompany him to the subway and on occasion take him to work, or he could not travel. The condition persisted and became worse nine years later when he began to suspect that his best friend was paying undue attention to his wife. The rumination and consequent anxiety necessitated her accompanying him to and from work and staying with him at work; but the fear of traveling and the other symptoms continued, becoming even more severe four years later when his brother, of whom he had been very fond, died.

This patient was seen only once, for purposes of psychiatric evaluation, as is the custom in the clinic to which he was referred, and there is no further information about him to help in understanding the development of his illness. His fear of traveling appeared to be fear of undertaking, as it were, a perilous journey during which, or at the end of which, there seemed to lie some terrible danger, possibly death. This anxiety had developed after seeing his son undertake such a journey, and it was relieved only when he was accompanied by his wife.

This type of phobic reaction to travel must be sharply differentiated from a true, specific agoraphobia. This latter refers to a fear of crowds[1] or a fear of being in or crossing open spaces,[2] such as a fear of the street itself; and it has a rather complex and elaborate structure based upon a warded-off impulse which submits to repression and displacement.[3] Symbolism, therefore, plays a very important role, and projection is prominent. While

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regression may be present as well, it is not nearly so significant.[4] Agoraphobia, in its strictest sense, is a psychoneurosis and constitutes a diagnosis in itself. Psychiatric and psychoanalytic investigators have reported different symbolic meanings behind the different fears.[4-7] For example, fears of temptation,[5] fears of being caught and punished,[6] as for aroused unconscious prostitution fantasies,[7] unconscious exhibitionistic and scopophilic impulses and other forbidden sexual interests,[6-8] and repressed sexual wishes have been reported underlying the fear of crowds.[4] Fears of the street, and open places away from the protective shelter of the house and from some particular person[4] may be due to unconscious incestuous impulses.[3, 8, 9] Related to this, the fear of the death of a particular person may be caused by unconscious destructive fantasies toward parents or sibling.[10] Associated with this, may be various birth fantasies as restitutive phenomena,[11] oral regressive defenses and fears,[12] and other symbolic meanings.[4, 7, 13] Still another factor reported in some agoraphobias is the defense against equilibrium eroticism.[14, 15]

This review is not intended to be complete or definitive in any sense, but it does tend to indicate the significance of the mental processes which have been felt to lie behind the manifest true phobic picture. No such unconscious symbolic meanings or elaborate structure is attributed here to the phobic reaction to travel. The fear of leaving the home and undertaking a journey felt to be perilous is, rather, associated with regression and with other panphobic reactions as well, and, therefore, is much more frequently encountered. It occurs, not only in neuroses and borderline states, but in schizophrenia as well—especially with the other panphobic conditions in pseudoneurotic schizophrenia. It seems less related to the specific phobias just described and more related to what Freud[16] called in his classification "common phobias"—"an exaggerated fear of all those things that everyone detests or fears to some extent, such as night, solitude, death, illness, dangers in general, snakes, etc." Like these, the anxiety about traveling is an exaggeration of a normal fear; it is a fear appropriate to early childhood, and it is indeed rooted in childhood; if it develops later in life it is a recurrence of such a fear and not a newly acquired one.[17]

As has been mentioned, it does not, therefore, represent a feared temptation and coexistent punishment for a warded-off impulse,

and it is thus characterized by a certain lack of any great degree of displacement and by a minimal amount of symbolism. As noted, it finds its origin in separation anxiety,[4] and it is reinforced by reality, by the presence of the dangers frequently encountered in traveling—namely that boats sink, airplanes crash, and that there are natural catastrophies, as well as the hostility of our own species on the way to our destinations. It was even worse in former times when the traveler from one place to another often enough took his life in his hands and exposed it to the none-too-tender mercies of his predatory fellows and indifferent nature; and the memory of this tends, perhaps, to persist and color our present attitude. In addition to those present and historical realistic factors, however, there are psychological ones as well in the form of the general human tendency to create the outer world in the image of the inner;[4] and it has been pointed out that various fears manifested in travel anxiety are based upon early childhood fears, such as castration fears, or fears of collisions, fears of being mutilated, robbed, raped, and killed[14]—and others. There are such childhood fears of being drowned, devoured, and swallowed up, to name only a few.[12] Many such anxieties have their origin, as suggested, in the wishes and fears of childhood, persisting in the unconscious. Thus projection reinforces reality.

All this contributes to the universality of this travel anxiety—universal at least in some mild degree—which is suggested by the origin of the word "travel"; it is derived, along with "travail," from the Old French *travaillier,* which word, along with the meaning of "to labor, to toil," also carried the meaning of "to be in torment," and was itself derived in turn from the Late Latin word *trepalium,* an instrument of torture.[18] This universality is also shown in the frequency with which this theme is encountered in our literature. It was present at the very beginnings of our culture, in its two main sources; the perilous journey and separation anxiety were Cain's punishment.[19] There was a sequence of trials for the Israelites after leaving Egypt[20] as related in the Bible, and there was a series of torments for the wandering Ulysses in Homer's *Odyssey.*

It is found not only in the beginnings of our own traditional literature, however; but, in an ancient Babylonian epic, the hero, Gilgamesh, having seen his friend die and falling ill himself, goes on a long and dangerous journey to a remote ancestor to discover

the secret of eternal life. After passing through many trials, including crossing the Water of Death, he finally arrives at his destination, only to receive the discouraging reply that immortality is not for man.[21] This frequently encountered tendency, incidentally, to link the idea of a journey and the idea of death—"the undiscover'd country from whose bourn/No traveller returns..."[22] —is certainly logical, considering the origin in separation anxiety of the phobic reaction to travel. Interestingly enough, when Jones[23, 24] discusses Freud's own travel "phobia," his acute anxiety at the moment of embarking on a journey by train, he also connects it with Freud's concern over death, and relates it to a fear of losing his home and ultimately losing his mother's breast. Apropos of this there is a remark by Kafka:[25] "I stand on the end platform of the tram and am completely unsure of my footing in this world, in this town, in my family."

Another such example of a perilous journey from a totally different source lies in the Jain literature of India. A parable[26] of 1,300 years ago describes the journey of a man wherein he encounters, among other dangers, a mad elephant charging him with upraised trunk, an evil female demon with a sword and a dreadful countenance, a terrible python with mouth agape, and so on. The tale is given a moral significance and covered with a theological fabric, just as in John Bunyan's *Pilgrim's Progress*, but like the latter, it is also ultimately concerned with the journey into death. Literature, legend, poetry, folklore, and fairy tales are replete with dangerous journeys, also with death or mutilation on the way or at the end—as in the Arthurian romances, Melville's *Moby Dick,* O'Neill's *The Emperor Jones,* and Coleridge's *The Rime of the Ancient Mariner.* At times the journey is connected with a search for some magical means of alleviating the terrors of mutilation and death, some magical cure or reassurance as to immortality and denial of death, as in the Grail quests and Dante's *Divine Comedy.*

The perils involved are, as in the Jain parable and in the *Odyssey,* often very suggestive of childhood fantasies and fears; for example, Jason's *Argo* must pass, in the quest for the Golden Fleece, between two terrible cliffs that open and close, crushing all things flying or sailing through. At times the attitude toward the journey is altered and the perils transformed, as for instance, in Cervantes' *Don Quixote* where the hero's status is lowered

from that of a noble elevated figure; one withdraws from him somewhat, looks upon his Chaplinesque trials and suffering from above, laughs at and pities him. The perilous journey here is turned into a farce, the giants into windmills, the dangers undone, and the tension relieved. One wonders how much the thrill of adventure and the joy of travel find their origins in the mastery of these terrors and the ego's consequent feeling of invulnerability. It is even interesting to note how often our games contain dangerous journeys—monopoly, parchesi, golf, croquet, and so on.

Another aspect of the phobic reaction to travel is the idea of life itself as the journey, as in James Joyce's *Ulysses,* where the hero is pictured as an isolated, homeless wanderer, the "Wandering Jew" in Dublin. And then life in turn can be subdivided into separate subjourneys—from the womb to the outside, from the home to school, then to work, into marriage, and into death—each step a separation and cause for anxiety. Rituals have been erected to help man through each of these movements—the *rites de passage* —the transition rites which Roheim[27] describes as dramatizing the transition as a rebirth and as a repetition of primal and universal anxiety which has been successfully overcome, or as a repetition of separation—with some part of the body acting as the equivalent of the original object. This paves the way, magically, for new ties or a symbolic unconscious renewal of old ones.

Other magical aids of a more regressive nature can be utilized as well. When Virgil has Aeneas descend into the gloomy subterranean world he equips him with the Golden Bough which Frazer[28] identified as the mistletoe and which he discovered was formerly believed to contain the seed of fire, the source of light and heat—an invaluable companion on such a grim journey. In fact, on further investigation, the mistletoe is found to contain the life of Jupiter himself and the seed of his power. Deities and superbeings are thus invoked, too—as, for example, Hermes, the god of travel and the conveyor of souls to the underworld, whose image was erected at crossroads and in towns; St. Christopher, who carried the infant Jesus with the world in his hands; or God Himself—*"adios," "adieu,"* and "good-by" (which is derived from "God be with ye"). Nowhere does the phobic reaction to travel reveal its origin in separation anxiety and its relationship to regression so clearly as in this, the seeking of the protection of

omnipotent beings, as the phobic person and the child seek the protection of seemingly omnipotent adults or parents.[29]

It is essential to distinguish between this, the phobic reaction, and the true phobia; for the distinction has not only diagnostic significance but important consequences and implications for therapy as well. The treatment of the true phobia with its complex structure and symbolic meaning tends to require a different approach (usually investigation and recovery of these meanings)[4] than treatment of the phobic reaction, which is more an incidental by-product of regression than the true phobia. The regression, or the cause of it, must often be the point of therapeutic attack here. However, it should be noted that although the phobic reaction to travel is, therefore, often simply a result of regression, and not an essential part of the illness from the point of view of the dynamics of the disorder, it can present itself—from a functional point of view—as the main obstacle to coming for treatment, or, if the patient does come, to further progress in therapy. The following patient, seen in the out-patient department of a general hospital,* very clearly manifested this fear of traveling, its origins, its recurrence, and the problems it presents for therapy.

He was first seen in 1951 at the age of 16, referred by his family doctor because of marked difficulty over urinating in public toilets. In addition, there was considerable restriction of his activities; he could not leave home for more than a few hours, and then would not go far. These difficulties had all been present for about five years, he said, since his father had seemed to withdraw from him, had stopped being attentive and had stopped going to places with him. The boy appeared to be very anxious; he kept only about four appointments, broke a number of others, and left the clinic. He was diagnosed as having a schizoid character disturbance with a conversion reaction; but the symptom, in retrospect, suggests the possibility of a latent homosexual conflict and an underlying paranoid mechanism.

He returned four years later, a tall, healthy-appearing broad-shouldered youth with a very immature manner, complaining of "going downhill." He was unable to seek or hold a job, had multiple physical complaints, and spoke of feeling weak and helpless in addition to the urinary difficulties which did not appear prominently in the picture. The phobic reaction to travel was extremely severe and incapacitating.

His history showed him to be the younger of two children, of Romanian-born Jewish parents. As children, he and his sister were very close to, and unduly dependent upon, the mother. Never social, they had few

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friends, never stayed away from home or went to camp. He rocked incessantly in his crib and later in his bed, and this continued until he came to the clinic. His sister married but continued to be very close to, and dependent on, the mother. The mother apparently was a somewhat masochistic, martyr-type who worked to support the family, took care of them but neglected herself. Although urgently advised to have a gall bladder operation, she postponed it because, as she said, who would take care of her husband and son? She infantilized and overprotected the boy. The father was described as immature, withdrawn, and passively dependent, an indifferent-appearing man with a markedly poor employment record, multiple anxieties, especially about foods, and many and various physical complaints.

After the boy graduated from high school, he tried a few jobs, worked at the post office at night for three months; but before the probationary period was completed, he quit, because of the onset of anxiety, chest and abdominal pains, and hypochondriasis. The actual precipitating incident (if there was one at all) was not known, and the onset seemed rather to have been insidious. There was some anorexia and weight loss; and he withdrew, felt different from his friends, spent his mornings sleeping at home and afternoons and evenings in the neighborhood candy store and luncheonette. There he overheard people speak of their illnesses and he would return home fearful that he was developing the same ones. He was very shy with girls, and at home he was irritable, hypochondriacal, and anxious about eating certain types of foods (as his father was).

He suffered from various other fears, such as fears of rats, a fear which compelled him to sleep in the parental bedroom. Regression was thus increasingly prominent as his illness progressed, and other panphobic reactions were present; but from the point of view of his functioning, the major incapacitating symptom was anxiety over traveling. This was, as already noted, extremely marked; and he feared riding in subways, buses, or cars; he refused to leave the neighborhood, either to look for a job, or for pleasure during the day or evening, for he would become extremely anxious if he tried to do so, whether alone or with friends. Coming to the clinic was a torment to him, and at first he had to be accompanied by his mother. Later, as he became more accustomed to the clinic and the psychiatrist, he came alone, but this travel anxiety returned for a while when he was transferred to another psychiatrist.

He was unable, however, to visit or stay with his sister, a short distance away from his home, and was able to travel as a rule only with his mother. Indeed, on the few occasions that he worked for a day or even looked for a job, he was accompanied by his mother, and the place of the job was near her place of work. Otherwise he and his father stayed home, where they complained about their physical difficulties, their bosses, and conditions

in general—and argued with each other. There was a marked similarity in their behavior and complaints, and this had even been noticed by the patient, who said that his father had always seemed a fearless sort of man until the patient's early adolescence; then the father developed his difficulties, became unable to hold a steady job for some reason, and progressed to his present status. The patient's difficulties first appeared then, too, after puberty, and intensified after finishing school—both of these occasions being crucial transition periods in the life of an individual.

The boy was started in psychotherapy in the out-patient department, one-half hour weekly, in November 1955, and continued with one psychiatrist until July 1956, without any change whatever. Reserpine was given during that time but did not help. A second psychiatrist began seeing him in September 1956 and continued to see him through June of the following year. In the sessions, the boy did not exhibit as much anxiety as his history suggested; rather he appeared extremely immature, continually complaining and worrying and demanding relief. His diagnoses varied from character neurosis with a possible underlying schizophrenic process, to pseudoneurotic schizophrenia.

Considering these diagnoses, the nature and chronicity of the disorder, his resources, and the amount of therapeutic time available for him it was felt that if he could just be gotten to work, this alone would have a considerable effect in reversing the process of regression and increasing his self-respect and thus causing improvement in his symptoms in general. It was hoped that this could be accomplished by establishing a situation wherein a positive transference to his psychiatrist could be built up, and that then, the patient, by identifying with the psychiatrist instead of his father and for the sake of the transference, would make some effort to combat his anxiety, to separate from his mother, and to go to work. This, as noted, would then have therapeutic value in itself.

The plan failed, for the positive transference did not occur. There was absolutely no movement in treatment, and his status remained the same. In June 1957, there was a conference which included the chief of the clinic, the caseworker who had been seeing the parents, and the therapist. In reviewing the situation, both psychiatrists felt that the clinic was, in effect, harming the boy by permitting, and even encouraging, his regression, and was thus tending to increase his fear of traveling and his separation anxiety. A certain equilibrium had developed between his mother, himself, and the clinic, all three of which reaffirmed his illness and further interfered with his going to work; and this in turn prevented any improvement in his condition. This vicious cycle, so to speak, had to be broken; and, considering the lack of any real positive transference, it was decided to discharge him.

This step was taken on the basis of clinical judgment, and after some consideration, for the psychological report had advised that the boy was a chronic schizophrenic, needed very badly the therapeutic relationship for relief of his great anxiety, and otherwise "might decompensate into a state of personality disintegration similar to the hebephrenic process." The caseworker felt similarly concerned from the impression she received from her contacts with the parents.

But it worked out otherwise. Before discharging the boy the situation was explained to him; he was told that it was felt that the clinic was not doing him any good, that it was just emphasizing and prolonging his illness, and that he would do much better if he stopped coming to the clinic. He complained about this, but was discharged anyway after a few months notice and considerable (but firm) discussion of the subject. Incidentally, he had been told that if he did get a job during this time the situation would be re-evaluated and the clinic might continue to see him. He did not try to find work, however. After discharge he had some significant increase in his anxiety; he tried to get back to the clinic, but was refused. He then got a job. The caseworker continued to see the parents, following the general program outlined by the psychiatrists of keeping the boy out of the parental bedroom, of helping the father to leave the house for a "Golden Age Club," of getting some medical assistance, and of trying to get the mother to stop infantilizing the boy and accompanying him everywhere. This latter endeavor was not completely successful for the mother tended to sabotage the caseworker's efforts.

Two months after discharge the caseworker saw the boy and noted that he appeared to be different. He walked with his head up, talked in a less infantile way, seemed more mature. He had been working for five weeks—the first time he had worked in many years. (It is possible that he got the job in order to return to the clinic, but he kept it, nevertheless, even after the clinic refused readmission.)

Despite his working, however, he continued to tyrannize his mother and instead of contributing to the home, took even more money from his mother than when he was not working. The father remained indifferent and aloof. Again the boy tried to return to the clinic, and again he was put off. The chief of the clinic saw him six months after discharge when again he made an effort to return and was refused. On this occasion as well, his general improvement was noted—"not so much qualitative as quantitative." During this interview the boy showed that he had some insight into and understanding of why the clinic had acted as it had.

He was seen by the second psychiatrist in July 1958, one year after discharge, when he came to the hospital for a hernia repair. His appearance was considerably improved over what it had been during psychotherapy. The phobic reaction to travel had disappeared completely. He

went anywhere—with anyone, or alone—at any time. The basic psychological disturbance was, of course, unchanged, and there continued to be evidence of regression as well as the persistence of panphobic phenomena. At home, he still fought with his mother and took money from her; there was some hypochondriasis, there was still some anxiety and tension, basic immaturity, and fears. There were, for example, fears of rats, and a good deal of anxiety with girls; but he held his job, had gotten a raise, was going to a trade school at night to better himself, and had even arranged to have his hernia operation when it would not interfere with his school and job.

He hoped, he said, that they would get it over with quickly so that he could go back to school and work and would not return to his former state, which he feared. He refused the offer of a postoperative stay at the hospital's convalescent home, said he was going to look for part-time work, such as sales work, during this period until he could go back to his regular job which was rather heavy work. He thought he needed more treatment for his other difficulties but did not want it at that time. This was the last contact he made with the hospital.

Summary and Comment

The phobic reaction to travel is defined, discussed, and differentiated from true agoraphobia. It has a certain universality and has no symbolic meaning apart from its origin in separation anxiety, which is then reinforced by the experience of reality and by the projection of unconscious infantile wishes and fears. It is thus a concomitant of regression and, as such, is often associated with panphobic reactions. It can present a major problem in psychotherapy where permitting, supporting, or even encouraging regression, no matter how unwittingly, may at times arouse or reinforce certain deep-seated, universal fears of childhood that have been lying dormant. Here treatment, oddly enough, can interfere with its own goals. Unlike the case of true agoraphobia which is a psychoneurotic symptom that usually must be dealt with directly in therapy, the therapist should concern himself here with the regression, for reversal of this process should produce in most cases a clearing up of the phobic reaction to travel without any attention paid to it directly. A case is reported which demonstrates these points.

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REFERENCES

1. Henderson, D., and Gillespie, R. D.: A Text-Book of Psychiatry. 7th edition. Oxford University Press. London. 1950.
2. Bleuler, E.: Textbook of Psychiatry. Macmillan. New York. 1924.
3. Freud, S.: Analysis of a phobia in a five-year-old boy. In: Collected Papers. Vol. 3. Hogarth and the Institute of Psycho-Analysis. London. 1949. Basic Books. New York. 1959.
4. Friedman, P.: The phobias. In: American Handbook of Psychiatry. Vol. I. Silvano Arieti, editor. Basic Books. New York. 1959.
5. Freud, S.: The Problem of Anxiety. Psychoanalytic Quarterly Press and Norton. New York. 1936.
6. Fenichel, O.: The Psychoanalytic Theory of Neurosis. Norton. New York. 1945.
7. Lewin, B. D.: Phobic symptoms and dream interpretation. Psychoan. Quart., 21: 295-322, July 1952.
8. Weiss, E.: Agoraphobia and its relation to hysterical attacks and to traumas. Int. J. Psycho-An., 16:59-83, January 1935.
9. Miller, M.: On street fear. Int. J. Psycho-An., 34:232-240, July 1953.
10. Abraham, K.: On the psychogenesis of agoraphobia in childhood. In: Clinical Papers and Essays on Psycho-Analysis. Basic Books. New York. 1955.
11. Deutsch, H.: Psycho-Analysis of the Neuroses. Hogarth. London. 1951.
12. Lewin, B. D.: Claustrophobia. Psychoan. Quart., 4:227-233, April 1935.
13. Katan, A.: Role of "displacement" in agoraphobia. Int. J. Psycho-An., 32:41-50, January 1951.
14. Rado, S.: Fear of castration in women. Psychoan. Quart., 2:425-475, July 1933.
15. Abraham, K.: A constitutional basis of locomotor anxiety. In: Selected Papers on Psychoanalysis. Basic Books. New York. 1953.
16. Freud, S.: Obsessions and phobias: their psychical mechanisms and their aetiology. In: Collected Papers. Vol. 1. Hogarth and the Institute of Psycho-Analysis. London. 1949. Basic Books. New York. 1959.
17. Freud, S.: A General Introduction to Psychoanalysis. Garden City Books. New York. 1943.
18. Webster's New International Dictionary. Merriam. Springfield, Mass. 1960.
19. Genesis. 4. 11-14.
20. Exodus. 14. 11-12; 16. 3; 17. 1-3.
21. Frazer, J. G.: Folk-Lore in the Old Testament. Tudor. New York. 1923.
22. Shakespeare, W.: Hamlet, Act III, sc. 1.
23. Jones, E.: Freud's early travels. Int. J. Psycho-An., 35:81-84, April 1954.
24. ——: The Life and Work of Sigmund Freud. Vol. 1. Basic Books. New York. 1957.
25. Kafka, F.: Meditations: On the Tram. In: The Penal Colony. Schocken Books. New York. 1948.
26. Sources of Indian Tradition. Columbia University Press. 1958.
27. Roheim, G.: Transition rites. Psychoan. Quart., 11:336-374, July 1942.
28. Frazer, J. G.: The Golden Bough. Macmillan. New York. 1958.
29. Alexander, F.: Psychoanalysis revised. Psychoan. Quart., 9: 1-36, January 1940.

THERAPEUTIC RATIONALE OF A PSYCHIATRIC DAY CENTER*

BY JULIAN MELTZOFF, Ph.D., AND A. A. RICHMAN, M.D.

One of the most significant postwar innovations in psychiatric treatment has been the introduction and development of day treatment facilities. Craft[1] has reviewed the development of psychiatric day hospitals, noting the work of Cameron in Canada, Bierer in England and Dzhagarova in the Soviet Union, and comparing admission statistics among the day hospitals in Moscow, Topeka, Bristol, Marlborough, Maudsley, and Nigeria. In 1958, the American Psychiatric Association sponsored a day hospital conference at which similar projects in this country were discussed.[2]

Craft[1] defines the day hospital as a hospital "where full hospital treatment is given under medical supervision to patients who return to their homes each night." A parallel development to the day hospital is exemplified in this country by such an institution as Fountain House, which provides social and recreational experiences for post-hospital patients who have been returned to the community. Another innovation is that of the day center associated with an out-patient clinic.[3] Day centers are now opening in a number of Veteran Administration clinics throughout the country.[4] The aim of the day center is to provide an intensive and extensive psychotherapeutic experience for marginally adjusted ambulatory schizophrenics. The patients spend the major part of each day at the day center, rather than being limited to the conventional periodic therapy hour. The center is designed to serve as a transitional phase in the rehabilitation of patients discharged from hospitals, as a preventive setting to forestall hospitalization, and as a means of improving the level of adjustment of chronic patients for whom hospitalization is not an imminent issue. It does not propose to duplicate the type of treatment offered either in full-time or day hospitals, but rather to provide an out-patient approach on an almost exclusively psychotherapeutic level.

The purpose of this paper is to discuss the therapeutic rationale of such an effort. First, however, it will be necessary to describe briefly the setting and program of an out-patient day center for psychiatric patients. The Day Center of the Veterans Administration Outpatient Clinic, Brooklyn, was established in November

*From the Veterans Administration Outpatient Clinic, Brooklyn, N. Y.

1958 for the express purpose of augmenting the traditional psychiatric treatment facilities existing in a large urban out-patient clinic. It was organized to meet the specific needs of an increasing number of marginally adjusted ambulatory schizophrenics who were not responding adequately to conventional therapeutic approaches. The day center is an integral part of the psychiatry and neurology service and is physically located adjacent to the mental hygiene clinic. It is divided into a workshop, recreational area, lounge area, lunchroom, library, and office. Facilities are available for a variety of activities which can be classified into such categories as active or passive, expressive or receptive, repetitive or variable, structured or nonstructured, social or solitary, motor or cognitive, competitive or noncompetitive, skilled or unskilled. There are no large, dangerous, or noisy power tools or equipment in the workshop. An assortment of crafts, such as woodwork, leather tooling, copper enameling, ceramics, drawing, painting, lettering, clay modeling, model making, as well as typing and other clerical activities, are represented. In the recreational area, there are facilities for pool, shuffleboard, and a variety of table games. Musical equipment includes a piano, hi-fi set, radio, tape recorder, and assorted percussion and rhythm instruments. The lounge is tastefully and comfortably furnished. The setting has been compared by patients to a home, with all facilities except bedrooms provided.

Staff offices are located in the center of these areas so that professional personnel can be in constant contact with the patient group. The staff consists of a psychiatrist, clinical psychologist, social worker, occupational therapist, trainees in clinical psychology, counseling psychology and social work, and a secretary-receptionist. A group of around 50 or 60 patients is active in the day center, coming from one to five days a week. The average daily census is from 20 to 25. This makes for a very favorable patient-staff ratio. Since the day center is neither a custodial unit nor a social club, the continual active participation of the professional team is central to the entire project. Although each member contributes his own specialized skills to the team effort, the shared primary mission is to develop and sustain the therapeutic milieu. To achieve this end, the staff mingles constantly with the patients and interacts with them throughout the day.

Psychotherapy is carried out within the framework of all ongoing activities, and is not restricted to formal interview techniques. Individual interviews and conferences with patients and family members, however, are carried out as dictated by the needs of the case.

Activity programs develop naturally out of the setting, and patients circulate freely from one area to another. Group activities include such events as a weekly patient-staff business meeting, discussion groups, special interest groups, music therapy sessions under the direction of a trained music-therapist volunteer, motion pictures, excursions to points of interest and special events in the community, and a monthly luncheon and birthday party. There have been such diverse trips as to the aquarium, museums, stock exchange, tea center, opera, theater, United Nations, and a boat ride around Manhattan. Although more conventional group therapy sessions are also held, all these group activities listed are participated in by professional team members who view them as group therapy.

Even though the entire setting is highly permissive and may appear to the patient to be entirely unstructured, staff members maintain close co-ordination with each other in order to give unified direction to the program and to the handling of each specific patient. The principal question asked before introducing any method of dealing with a patient or any group activity, concerns its therapeutic rationale. It is to this question that this paper is addressed.

Therapeutic Rationale

Psychotherapy in the day center is a form of milieu therapy designed to modify maladjusted behavior patterns by altering the daily experiences of the patients during a significant portion of the day and helping them to synthesize these new experiences into their life patterns. When appropriate, therapists also deal with intrapsychic and situational variables, taking their cues from both verbal and nonverbal behavioral expressions of the patients.

There are many ways of characterizing a group of chronic ambulatory schizophrenics. For present purposes, the writers have culled several general characteristics which appear in a population of this sort, and will describe the way in which the therapists in the day center deal with these disturbances.

Social Maladjustment

Social maladjustment may take the form of unskilled interpersonal relations, distorted relations, or withdrawal and social isolation. Some of these patients have never acquired the basic skills of interpersonal relations, and lack any feeling of belonging or group identity. In the process of having withdrawn from society for many years or having been isolated in neuropsychiatric hospitals, others have lost much of the facility in interpersonal relations that they once might have had.

As members of a selected group in whom the staff and community are interested, identification with the group soon emerges among day center patients. As early as feasible, social interaction among these patients is encouraged. They are led into, guided, and supported through, situations calling for social interaction, and their tentative efforts are reinforced. The staff works continuously on this problem by whatever means are available. These include: (a) manipulating the environment—i.e., introducing two or more patients to each other and stimulating their interaction, organizing a small group discussion or activity, maneuvering a patient into a situation that requires participation with others; (b) direct suggestion—i.e., advising a patient to involve himself in specific activities; (c) reinforcing socially acceptable responses and discouraging unacceptable ones—i.e., praising a patient after observing an adaptive response, discussing more effective ways to deal with a given situation when observing a maladaptive response.

The day center is thus a laboratory for living, where patients repeatedly try out different varieties of social behavior. They are supported when they fail, and helped to understand the reasons for the failure so that the experience can become a corrective one. They are given suggestions about the handling of similar situations in the future, and receive reinforcement when they succeed. It is more of a hope than an assumption that these corrective experiences will transfer to social situations outside the clinic. Nevertheless, some efforts are made in this direction as well. Social groupings and relationships formed in the day center often carry over to the evenings and week-ends. Patients visit each other's homes and go out together into the community. Visits, organized by the day center, to various places of interest have been followed up by individual patients and patient groups on their own.

As previously mentioned, when the patients go on an excursion into the community, they are accompanied by staff members. Therapists are thereby enabled, not only to observe patients in a community setting, but to deal first hand with their anxieties and reactions. One patient, for example, was induced to take his first subway ride in seven years. Surrounded by his friends and therapists, he was able to overcome his acute anxiety and go through with the trip. These visits also aim to reawaken the patient's awareness of the larger community outside his living quarters and the day center, and to introduce him actively into the utilization of community facilities and participation in community affairs. In the process, the staff members serve as appropriate role models after which patients can pattern their behavior in public.

As one aspect of interpersonal relations, there is marked psychosexual regression or lack of development in most of these patients. Object relations with members of the opposite sex are practically nil. Most of the patients are single, and some are separated or divorced. Women staff members and volunteer personnel serve as objects for redeveloping heterosexual interests. Although not themselves attainable, they are used by patients as a training ground for the expression of infantile, childish, adolescent, and emerging adult behavior patterns. This problem, of course, must be handled with great skill on the part of the female personnel.

Vocational Maladjustment

The majority of the day center's patients have been vocationally incapacitated for some time. Most have very sporadic job histories, have not had regular employment in many years and are currently unemployed. Lessening of this vocational incapacitation is one of the explicit goals of the day center. The aim is not merely to hope for vocational rehabilitation as a concomitant of improved emotional status, but rather to intervene directly in the maladaptive pattern.

The mere thought of employment is highly threatening to many of these patients in the early phases of treatment. Others ruminate about it, but are unable either to organize their ideas in a logical and realistic manner or to translate them into effective action. In the day center, the patients are guided into a variety of pre-vocational work experiences. They learn to get up in the morning and travel to the clinic, with a plan and purpose for the day.

While in the day center, they are introduced to an assortment of "work projects." These are carefully graduated in accordance with each individual's own interest and tolerance. The patients gradually learn to take on a project, plan it, work on it persistently, and see it through to completion. In the process, they learn how to take out tools and equipment, return them to their proper places, and clean up after themselves. Small gains in such seemingly elemental aspects of working are sometimes won only in the most laborious fashion. When the patient is able to tolerate discussion of employment, the process of vocational counseling is concurrently initiated. Since the counseling psychologist and the patient already know each other well, the transition is an easy one. The occupational therapist is in a position to report many highly meaningful observations about work habits, skills, and emotional reaction to working. The psychologist has also been able to get a first-hand picture of the patient in work situations.

Testing, interviewing, and the entire counseling process is carried out over a considerable time, and is co-ordinated with the various activity programs. Liaison has been established with sheltered workshops in the community, the State Employment Service, and other public and private community resources. A patient is placed only when it is felt that he has a reasonable chance of succeeding. Should he fail, he immediately returns to the day center, and the process is again continued from there.

Thinking Disorder

Impaired reality testing, poor judgment, and related disturbances of cognitive functioning are handled in much the same way. Throughout the day, in a variety of situations, the staff is involved in helping the patient understand and interpret reality in the hope that relearning will take place. Staff members serve, not only as sounding boards against which the patient can test reality, but as active guides in the direction of logical and acceptable judgments. Everything from the simplest perceptual judgments involved in craft work to complex social judgments are subjected to these corrective experiences. In addition, discouragement of autism and self-preoccupation seems to accrue as a by-product of contact with people and exposure to absorbing activities.

Affective Control

Characteristic of the day center's patients is a defect of affective control which can take any of several forms. Either there is excessive control with no display of affect, insufficient control characterized by inappropriate affective outbursts, or some alternation between the two. The overcontrolled patient does not represent so much of an immediate problem to the community or family as the undercontrolled patient, does not attract too much attention, and is often neglected in consequence. The patient with insufficient or variable control presents much more of a social management problem. The day center provides an atmosphere where it is "safe" for the overcontrolled patients to express affect. The staff attempts to stimulate such patients through any of a variety of media, and then to reinforce any expressions that are elicited. As these patients gradually begin to smile, to laugh, to get angry, or to develop warm feelings toward other people, they often move into a phase of inadequate or inappropriate control. This, too, must be recognized and brought under control by laborious trial and error on the part of the patients and corrective guidance on the part of the therapists.

The modes of expression of patients' feelings, as well as their defenses against these feelings, are brought to conscious awareness. Once identified and recognized, they can be talked about more easily and an attempt can be made to regulate them. Patients with insufficient control are either guided into tranquilizing activities or given socially acceptable outlets for controlled expression. As often as feasible, the breakdown of the affective control processes is dealt with in relation to the dynamics of the case. Specific activities designed to modify feeling states and reconstitute defenses are assigned.

Self-Percept

Most chronic ambulatory schizophrenics show pervasive signs of low self-esteem, engendered by life-long patterns of failure and non-accomplishment. Since they have been labeled psychotic and viewed as "difficult," "sick," "confused," they see themselves as different from others, forgotten, and unwanted. After prolonged hospitalization many have, to all intents and purposes, lost their identities and become "non-entities" destined for aimless drifting on the fringes of society. In the day center, systematic efforts are

devoted to the development or restoration of self-esteem. Projects and assignments are carefully graded.

A patient is not given anything to do, no matter how simple, unless there is a reasonable chance of his succeeding. One of the therapists is always there to support him should he fail, and to praise and reinforce minor successes. The patient becomes aware of his own potentialities and can thus be led in time to larger and larger successes. For example, one patient was helped to develop from the stage of attempting and succeeding at some extremely inconsequential tasks, to the point of becoming editor of the day center newspaper. In the latter capacity, he is regularly assuming responsibilities, seeing his writings and name in print, and receiving ample well-deserved recognition and praise for his efforts. The next more difficult step is the pitting of his self-esteem against the assaults of the community at large. When he finally takes his place as a functioning member of the community, it can only be hoped that he will have achieved a level of self-esteem that will permit him to absorb the almost inevitable minor setbacks he will undergo.

Immaturity

A general pattern of immaturity is observed in these patients. Their behavior is often "sub-adult" if not "childlike." This has already been discussed to some extent in describing their interpersonal relations and affective responses. There appears to be a pervasive reluctance to assume responsibilities in life, accompanied by marked dependence upon others. The way in which these problems are handled defines one of the principal differences between a day center and an installation committed philosophically and practically to custodial care. Every effort is made to encourage independence and responsibility at various levels rather than to foster dependence. The general therapeutic formula is to assign, guide, and follow up graded responsibilities, and to reinforce independent effort.

The first level of responsibility considered is responsibility to the self. This includes care of one's own physical being and needs, and the assuming of responsibility for one's own behavior. The second level is responsibility to one's fellow-man, and the third is responsibility to the community. Responsibility for the maintenance of one's personal self is dealt with in part by guiding and instructing patients on matters of personal hygiene. When neces-

sary, they are advised to bathe, shave, and comb their hair, and are praised for improved physical appearance. Reinforcement for improvement is usually obtained by them both in and outside the day center. When they cease to look so negatively distinctive, they find themselves treated better socially. Increased pride in self-appearance goes along with increased self-esteem and a socially acceptable percept of the self.

The therapists are much concerned with the patients' assuming responsibility for their own actions and for planning their own activities. Antisocial acting out is dealt with on the spot, discussed, and interpreted. In many cases staff members assist patients to work out daily programs for themselves. This is considerably different from having a fully-prepared schedule of activities to which patients are assigned and passively follow. In all cases, patients are responsible for cleaning up after themselves, putting away their tools or craft materials, and washing their own eating utensils.

Each patient has his own storage area for his projects, materials and utensils, and is expected to maintain it. Where help is needed, it is given, but the general attitude is, "You are an independent individual and are responsible for yourself, your things, and your behavior." Responsibility for the welfare of others is encouraged. An effort is made to get patients to show new members around and take them under their wings until they are acclimated. It is not infrequent for one patient to accompany another into the community on a personal errand that has aroused undue anxiety. The group spirit and shared responsibility become apparent when the patients go on trips and social events sponsored by the day center.

The next level of responsibility is to the day center community itself. Here patients are assigned responsibilities ranging all the way from emptying ashtrays to editing a newspaper. Examples of responsibilities at different levels are: 1. In charge of neatness of a small area. 2. In charge of the maintenance of equipment. 3. Member of a committee. 4. Chairman of a committee.

Ultimately the patient is faced with the responsibility of obtaining a job and contributing to the support of himself and others. It is hoped that a backlog of successful experiences with responsibilities at various levels will help prepare him for this step.

Motivation

Underlying many of the areas already discussed is a motivational problem characterized by a restricted sphere of interest and excessive preoccupation with autistic processes. The general apathy that accompanies a monotonous goalless existence is compounded by reluctance to attempt anything new for fear of repetition of failures of the past. The initial approach in the day center is to expose the patient to a variety of potentially interesting activities in the hope that one or more will attract his attention. Alert for any sign or expression of interest, the staff guides the patient into some appropriate activity. The staff members stay with him, give him special attention and support during this initial exposure, and stimulate his motivation to go further. During the next few days the patient is guided into setting small, achievable goals. More ambitious goals are established as time goes on, and the variety of interests is expanded.

The final step is that of assisting the patient to set life goals that extend beyond the day center in the direction of full integration into the community.

The entire day center experience is one which stimulates new outlooks, interests, experiences, and associations in the patients. Under the guidance of a staff that is responsive to individual needs in this intimate atmosphere, patients seem to acquire renewal of motivation for interacting with the environment, acquire a new purpose in life, and acquire a revised scheme of living.

Summary and Conclusions

The therapeutic rationale of an out-patient neuropsychiatric day center has been described as a unified and planful intervention in a set of highly maladapted behavior patterns and attending feeling states. The day center approach to the treatment of the ambulatory schizophrenic is discussed as a type of milieu therapy, on an out-patient basis, which is designed to modify patterns of social and vocational maladjustment, and to deal with the disorders of thought, affective control, and motivation so commonly seen in this type of patient.

The therapists maintain realistically modest notions about how far they can go in modifying major psychoses of long duration. They do, however, share the conviction that almost any patient can be helped to achieve a higher level of adjustment. So far,

there have been enough instances of increments to give the firm impression that this approach to the problem holds much promise for the future.

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REFERENCES

1. Craft, M.: Psychiatric day hospital. Am. J. Psychiat., 116:251-254, 1959.
2. American Psychiatric Association: Proceedings of the 1958 Day Hospital Conference. Published by the American Psychiatric Assn., Washington, D.C., p. 112.
3. Richman, A.; Meltzoff, J., and Lesser, W.: Neuropsychiatric day center. Paper presented at Veterans Administration Central Office Conference on Day Care Program, June 1959. Unpublished.
4. Weinstein, G. J.: Pilot programs in day care. Ment. Hosp. 11:9-11, 1960.

CELIAC SYNDROME IN THE CASE HISTORIES OF FIVE SCHIZOPHRENICS

BY HAROLD GRAFF, M.D. AND ALLEN HANDFORD, M.D.

Within a recent statistical year* at the Institute of Pennsylvania Hospital (IPH) five young adults have been admitted with a clinical diagnosis of schizophrenia who present a history of celiac syndrome in infancy. In a psychiatric hospital with relatively few admissions a year, such an observation, the writers believe, becomes worthy of further consideration. Furthermore, an extensive search of the American literature reveals no report of overt psychosis in the subsequent histories of patients who once had celiac syndrome.

Celiac syndrome, a symptom complex consisting of (a) vomiting, (b) intermittent diarrhea, (c) steatorrhea, (d) weight loss, (e) abdominal distention, and (f) increased stool volume in the first years of life, is treated by a rigid diet, and it provides fertile ground for the development of emotional disturbances. Such have often been reported in patients during the active period of the disease.[1] Early writers have reported the frequency of mental symptoms such as depression, paranoia, neurasthenia—usually occurring during severe attacks—attributing them to the patients' dehydration and starvation.[2] Despite Gerard's note[3] that such children often show schizoid withdrawal, the experience of Cooke et al.[4] has been that in long-term follow-ups on adults still subject to attacks of celiac syndrome, symptoms associated with anxiety states are rarely encountered. Investigators, such as Herter[5] and Bennett et al.,[6] assert that mental powers are retained, although the patients are irritable and exacting.

In the present series, the patients gave no recent history of symptoms of celiac syndrome, and none were observed during their hospitalization at the Institute of Pennsylvania Hospital. Thus, their psychoses were not accompanied by exacerbations of their childhood diseases.

Case Reports

Case 1

B.L., a 24-year-old, white, single girl, showed gradual disorganization of thinking, lability of affect, and nausea of several

*July 1, 1959 to June 30, 1960.

months duration, culminating in overt fears of sexual mutilation, a phobia for birds, depression, increased psychomotor activity, and insomnia. She had become seclusive and had begun to misinterpret the gestures of the other students at the special boarding school which she attended.

She was the second child and second girl of three siblings. Her mother's pregnancy and delivery were normal. She was bottle-fed. At an uncertain time during the first three years of life, she developed celiac disease and was treated with "a diet low in starch" until late childhood. Motor development was reported delayed by this illness. She was a fretful baby, crying a great deal. At the age of three, she was considered "not normal mentally." A psychotherapist said, "She was never sufficiently in contact with reality to achieve a great deal." A psychiatrist diagnosed her as schizophrenic, with low normal intellectual potential. At the age of nine, she entered a special school where she had lived until her hospitalization.

Her mother and father are both living. Her father is president of a commercial finance company and is considered jovial, but aggressive. He has always insisted on the best of care for his daughter. The mother has been an invalid since the removal of a brain tumor when the patient was 15. The siblings are in good health.

The child's medical history revealed measles and German measles, as well as the celiac syndrome in childhood. There have been only minor disorders since then. The mental status examination showed a restless, anxious, frightened young woman who was emotionally labile and spoke in a word salad of her delusional fears. Physical, neurological, and laboratory examinations showed results within normal limits.

During hospitalization at the Institute, B.L. continued to be emotionally labile, having many tantrums. She averaged one stool a day and had no diarrhea. Her appetite was good. Twice she vomited her meals after upsetting experiences.

Her final diagnosis was schizophrenic reaction, chronic undifferentiated type.

Case 2

R.P., a 19-year-old, white, single youth, entered IPH in April 1960, from a special school devoted to behavior problems. He had

been acting in a bizarre manner and appeared to be hallucinating. He also had difficulty in eating and had to be encouraged at each meal.

He was the only child of a Jewish family. He was bottle-fed on a strict schedule, and from 13 months to three years suffered from celiac disease, with inability to digest regular food, and with constant diarrhea. When he was 13, he was seen by a child psychologist for tests and therapy. At 16, at summer camp, he developed delusions of reference and felt "every camper had tears in his eyes." Psychiatric help was sought, and in treatment he intermittently expressed delusional ideas and acted out psychotically. He failed to attend school, stole an automobile, and once impulsively climbed a 300-foot radio tower. His personality was described as withdrawn, he had few friends and always felt "left out."

His parents are both living. His father is described as passive-aggressive and a strict disciplinarian. His mother who is rather phobic, is indulgent and overprotective.

Results of physical, neurological, and laboratory examinations were all within normal limits. His mental status was bizarre, rambling, incoherent, and irrelevant. His affect was flattened. In the hospital, his appetite has been good and he has gained eight pounds. There have been no bowel complaints.

His diagnosis is schizophrenic reaction, chronic undifferentiated type.

Case 3

R.S., a 23-year-old, white, single, Protestant male, entered the Institute in March 1960. His parents stated that "he has resentment against everything that meant something before." While attending college, he had begun to have delusions about the second coming of Christ, and had attempted to resurrect a body at a local funeral.

He is the oldest of four children. For the first 18 months of life he suffered from celiac disease, which was controlled by diet. He was otherwise considered a "perfect child, almost too good." In school, he was initially an excellent student, leading his class. In college, however, he was barely "getting through," consistently turning in his assignments late or never, feeling that if they could not be perfect, he would rather not do them at all. He is other-

wise slow and serious, has had few friends, and no sexual experience.

His father is successful, quiet, and passive, while his mother is considered controlling, strong-willed, and seductive. Many members of both the maternal and paternal families have been treated for mental illness. There is a history of celiac syndrome in the father's family.

Physical examination of R.S. revealed some unsteadiness of gait and widening of base because of treatment with phenothiazines. This cleared rapidly on discontinuation of the medication. Results of the laboratory studies were normal. In the mental status examination, the patient was described as quiet, sullen, and sitting with his head bowed and his eyes closed. He showed flight of ideas and tangentiality. His affect was flattened. He was bizarre for the first few days in the hospital and often banged his head against the wall. His behavior improved after the first week, but he remained depressed until his transfer to another hospital. He gained 11 pounds during hospitalization, and there were no complaints of diarrhea or gastro-intestinal trouble.

His diagnosis was schizophrenic reaction, chronic undifferentiated type.

Case 4

L.D. entered IPH in February 1960. It was his first admission. He was 31, white, single, and Jewish. He was brought to the hospital against his will, complaining that his psychiatrist was controlling his life and telling everyone that he was homosexual. He had had paranoid delusions intermittently for five years, and for six months had been unable to work and had secluded himself at home. He threatened to wreck the house if his parents hospitalized him.

He is the oldest child and the only male child. He was breast-fed for his first nine months; and, at seven months, an attempt at weaning was halted when he developed celiac disease, which lasted until he was three. He was treated with a fat-free, gluten-free, low carbohydrate diet. His grades in grammer school, high school and college were excellent, and he was gregarious and well-liked; but he failed in graduate school and, thereafter, entered into a long period of intensive psychoanalytic treatment, toward the close of which overt paranoid ideation began to appear.

L.D.'s mother, a scientist, is dominant, aggressive, compulsive, and of superior intellect. She has tended to guide her son's every move and states that when the patient left her, "he went to pieces." His father, a physician, is described as cold, distant, critical, and immersed in his profession to the exclusion of his family. His sister is reported to be normal.

The physical examination and laboratory findings were within normal limits. The mental status examination revealed the patient to be a benign, friendly, slightly obese man who was voluble, circumstantial, mildly protesting his hospitalization, and expressing some paranoid ideas. His affect was somewhat inappropriate and his mood slightly depressed. While in the hospital, he lost five pounds as a result of his increased activity. There were no bowel problems. He was treated with a phenothiazine, experiencing a gradual amelioration of his paranoid ideation.

His diagnosis was schizophrenic reaction, chronic paranoid type.

Case 5

O.C. is a 21-year-old, white, Jewish male, in his first admission to IPH. His presenting symptoms were depression, excessive drinking, difficulty with school work, anorexia, insomnia, and difficulty in concentration. He entered the hospital in December 1959, after a suicide attempt. This was his second episode of depression, the first occurring when he was 12.

The patient is the second child and first male born to a successful merchant family. The pregnancy was full term, but it was "very painful... especially during the early part," because of excessive maternal vomiting. Almost from birth, the baby suffered from the celiac syndrome; and at the age of one he weighed only 12 lb., 2 oz. (birth weight 8 lb., 6 oz.). He received several blood transfusions. When placed on a banana and rice diet, he began to improve, although bowel function was not under full control until the age of nine. As a child, O. C. was described as too quiet and passive, and embarrassed by his small stature. He did well scholastically, but "was always getting into an awful lot of trouble." He was graduated from college with honors and entered medical school; and it was while he was at medical school that feelings of failure and depression developed. His family considers him the weakest member of a strong group. He tends to be orderly

and methodical and to become depressed easily when frustrated or disappointed.

His mother is anxious and controlling, subject to frequent depressions. She has been a successful business woman. The father, a business executive, is cold and manipulating. The patient's sister is essentially normal.

Physical and laboratory findings were normal. In mental status examinations, the patient was composed. He was well-groomed. He was voluble, logical and goal-directed; but his affect was depressed, flattened and anxious. Psychometric testing suggested a possible schizophrenic reaction in a man whose obsessive-compulsive defenses formerly were sufficient to maintain him in stressful life situations. The patient is being treated with intensive psychotherapy and has done well. His appetite is good and there have been no gastro-intestinal complaints.

Final diagnosis had not been made at the time of this paper, but psychological studies suggest a schizophrenic reaction, schizo-affective type.

Review of Cases

A review of the five cases reveals many common factors, even though the small number precludes attributing statistical significance to them. Four of the five patients are male. The IPH has, as shown in a survey of the past five years, admitted an average of 31 male schizophrenics as first admissions each statistical year. Of the 37 first-admission, male patients admitted in the year 1959-60 and diagnosed as schizophrenic, four had histories of celiac syndrome, or a total of 10.8 per cent. All of the males are either the oldest child, or the oldest of their sex. Three of the five patients are considered very bright, only the female exhibiting mental retardation since early childhood. All of the male patients have histories of obsessive-compulsive behavior, high scholastic achievement in their early years with scholastic failure in subsequent years, antisocial behavior during the gradual onset of their psychoses, and depression with the psychoses. Their mothers are consistently noted to be anxious and controlling. Their fathers are successful business or professional men who are cold and distant or passive in dealing with their children.

Discussion

Grinker[7] reports that disturbances during the earliest period of life impose a great effect upon the ego. He states that severe feeding and bowel disturbances color the emotional life of the individual far beyond the period of physiologic dysfunction.[8] He illustrates this in the report of the treatment of a young man who had celiac syndrome as an infant, and who had a history similar to those of the four men reported in this paper, although a specific psychiatric diagnosis was not given. Parents' anxiety over a severe illness such as celiac syndrome, with great attention to specific diet and concern over the number and quality of bowel movements, creates a psychologic pattern continuing until adult life, even when the child's physiologic symptoms are gone. Obsessive-compulsive behavior is fostered, as well as high standards of achievement. With an increased life stress, as in the cases reported here, such defenses may become inadequate, and a psychotic episode may follow. These findings suggest that further studies are required to elucidate the relationship between such body illnesses in childhood and later psychosis.

Furthermore, it is interesting to speculate on the fact that a high banana diet is used with good effect in patients with celiac syndrome.[9] That bananas are high in serotonin precursors, and that ingestion of them produces a high level of serum serotonin, has been recently reported.[10] Recent studies have shown that serotonin imbalance is one characteristic of the schizophrenic syndrome.[11]

Noting that errors of carbohydrate metabolism have also been found in infants with celiac syndrome, some pediatricians have used subcoma doses of insulin with good results in these patients,[12] as it has been used in the treatment of schizophrenia.[13] Insulin therapy in the treatment of schizophrenia has been noted by one of the writers (H.G.) to alter the level of serum serotonin. These suggestions that the organic components of both celiac syndrome and schizophrenia have something in common afford a basis for further study.

Summary and Conclusions

Celiac syndrome in infancy was encountered in the case histories of five young adults diagnosed as having schizophrenia. A review of the literature reveals no previous report linking celiac syndrome and schizophrenia. Other similarities of the five cases were dis-

cussed. Speculation as to the psychic and biochemical relationship between celiac syndrome and schizophrenia suggests a basis for additional research.

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REFERENCES

1. Prugh, D. G.: A preliminary report on the role of functional factors in idiopathic celiac disease. Psychosom. Med., 13:220-241, 1951.
2. Cook, W. T.; Peeney, A. L. P., and Hawkins, C. F.: Symptoms, signs, and diagnostic features of idiopathic steatorrhoea. Quart. J. Med., NS., 22: 59-77, 1953.
3. Gerard, M.: The psychosomatic concept in psychoanalysis. In: Emotional Problems of Early Childhood. G. Caplan, editor. Basic Books. New York. 1955.
4. Cooke, W. T.; Peeney, A. L. P., and Hawkins, C. F.: Op. cit.
5. Herter, C. A.: On Infantilism from Chronic Intestinal Infection. Macmillan. New York. 1908.
6. Bennett, T. L.; Hunter, D., and Vaughan, J. M.: Idiopathic steatorrhoea (Gee's disease). A nutritional disturbance associated with tetany, osteomalacia, and anaemia. Quart. J. Med., NS, 1:603-677, 1932.
7. Grinker, R. R.: The effect of infantile disease on ego patterns. Am. J. Psychiat., 110:290-295, 1953.
8. Grinker, R. R.: Psychosomatic Research. Norton. New York. 1953.
9. Haas, S. V.: Celiac disease and its ultimate prognosis. J. Pediat., 13:390-399, 1938.
10. Crout, J. R., and Sjoerdsma, A.: The clinical and laboratory significance of serotonin and catechol amines in bananas. N. E. J. Med., 261:23-26, 1959.
11. Woolley, D. W.: Participation of serotonin in mental processes. In: Chemical Concepts of Psychosis. M. Rinkel and C. B. Denber, editors. McDowell, Obolensky. New York. 1958.
12. Schlesinger, B., and Keele, K. D.: A case of caeliac disease showing unusual features successfully treated with insulin and glucose. Arch. Dis. Child, 10: 149-156, 1935.
13. Munn, C.: Insulin in catatonic stupor. Arch. Neurol. & Psychiat., 34:262-269. 1935.

A BASIC PSYCHOLOGICAL ORIENTATION APPARENTLY ASSOCIATED WITH MALIGNANT DISEASE

BY LAWRENCE LE SHAN, Ph.D.

The concept that personality is one of the multiple factors which play a role in the etiology and pathogenesis of malignant disease rests today on a number of studies in the professional literature. This material, composed of clinical observations, experimental researches and evaluations of statistical data, has been reviewed by Kowal,[1] by LeShan and Worthington,[2] by Petschke[3] and by LeShan.[4] In the last and most comprehensive of these reviews, this area was summed up as follows:

1) There seems to be a correlation between neoplastic disease and certain types of psychological situations. 2) The most consistently reported, relevant psychological finding has been the loss of a major emotional relationship prior to the first-noted symptoms of the tumor. 3) There appears to be some relationship between personality organization and the length of time between the appearance of a neoplasm and the death of the patient. 4) There may be some relationship between personality organization and the type or location of a cancer.

Much further research in this field is needed to explore the validity of these hypotheses and to develop others. The most sensitive and thorough tool for these purposes appears to be intensive psychotherapy, a method that has been little used in this area. It is the purpose of the present paper to report on a study of patients with malignant tumors by means of this technique.* It will concentrate on one particular finding which was observed consistently in these patients.

Neither the available literature nor present research hypotheses offer an answer to the problem of specificity in cancer—that is, if one *particular* kind of personality constellation, set of emotional stresses, etc., is highly correlated with cancer or whether a wide variety of emotional conditions can be related to the neoplastic condition. The present report deals with one factor which has been observed repeatedly in the intensive psychological exploration of cancer patients and has not been observed in the usual cross-section of patients seen in office practice and mental hygiene clinic experience. Nor, to the author's knowledge, has it been heretofore reported in the psychological literature. In a

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series of 18 cancer patients who were studied by means of intensive psychotherapy, this factor was observed in 16. A series of 15 noncancer patients (neurosis, character disorder, and incipient psychosis) was studied by the same type of psychotherapeutic exploration that was used with the cancer patients, and by the same therapist.* It was observed in only one of these patients. The writer will call this factor "despair."

Despair

As observed in the emotional life of cancer patients, "despair" appears to be a basic *Weltanschauung,* with three secondary components. The central orientation seems to be a bleak hopelessness about ever achieving any meaning, zest or validity in life. This is much more barren and hopeless than the feelings expressed by depressed patients. There is an absence of real relatedness to the cosmos, which makes it impossible for love to bridge the gap or for the relating aspects of anger, resentment, jealousy or other hostile-aggressive emotions to ease the aloneness. The alienation from others of the depressed, the suicidal or the otherwise self-destructive patient, is less; and a contact is often maintained with others through his hostility toward them. He still has his cathexes, although they may be composed primarily and consciously of hostile rather than of loving elements.

The patient in despair does not have this channel: he feels basically, absolutely alone. At the deepest emotional level he can neither love nor hate since he does not relate to others. He does not despair over "something," he despairs over "nothing," the absence of anything with meaning.**

The three secondary components appear to be: (1) *A lack of any belief that outside "objects" can bring satisfaction.* Any meaning through relating, the patient feels, can only be—at best—temporary, and inevitably will bring disappointment and pain. (2) *An absence of faith in development.* There is no belief that

*Some details of the type of psychotherapy used and its rationale have been presented elsewhere by LeShan and Gassmann.[5]

**As Kierkegaard has put it, "So to despair over something is not properly to despair."[6, p. 152] This is further illustrated, perhaps, by an exchange that took place during a therapy session. *Therapist* (after patient had expressed some negative feelings about herself): "What do you think it is that makes you so angry at yourself—that makes you feel so guilty? Do you feel you have done something to deserve this?" *Patient*: "No, I've done nothing. You don't understand, doctor. It's not that I've done or been anything. It's that I've done *nothing* and felt *nothing.*"

time—or the patients' own development—can change this condition. Individuals who are not in despair always see the possibility of growth or change affecting the painful condition in a positive way. The person in despair does not see this as a possibility. (3) *An absence of belief that any action the patient takes in his proper person—as himself—can ease his aloneness.* To be what he is, is to be rejected. No amount of effort can change this. Generally, major efforts have been made—often gigantic amounts of energy poured into attempts to reach others—these have failed and seem doomed to fail eternally.

It is not possible to give pure examples of despair in the words of specific patients. The feeling emerges slowly, in protean forms and at many times; it is possible to qualify and explain the individual quotations in other ways. Nevertheless, a few examples may give some of the flavor of the feeling.

"It's as if all my life, I've been climbing a very steep mountain. It's very hard work. Every now and then there are ledges I can rest on and even enjoy myself for a little while. But I've got to keep climbing. And the mountain I'm on has no top."

"I found I hated working for the union. It was too late to go back to music although I tried. I knew I'd have to stay in the business end for good. There was no way out, no matter what I did."

"The more I tried to tear it down, the higher and thicker became the wall of thorns I had built around myself. I couldn't get past it to other people. I feel like *'Dornrosen'* [the fairy tale princess who slept inside a circle of thorns until a prince breached it and awakened her] except that the forest has grown so thick that no one will find me. The path is too overgrown ever to be used again."

"No matter what I did it didn't work. I lost my ability [to write] and so did Tom, and the more we tried, the worse it got. I gave up everything for him and—I see now—it destroyed us both. We had a mutual strangulation society. There just didn't seem any way out . . . I often thought I'd only escape by dying."

"You know how it is with a house with no insulation and with cracks in the walls. The more you put in heat, the more it leaks out. You can never get it warm. I always knew that's how it was with me in life. I had to keep putting out and putting out, and there was never any reflection back at me. If I was going to get warm inside, I'd have to do it alone, and no matter how much you do you can't do that."

"I'm like 'Rappaccini's Daughter' [a story by Hawthorne]. I need love and can respond to love, but I poison them [anyone she loves] because they

don't have my immunity to my own poison. . . . I don't guess you or anybody else knows what it means to have no hope at all."

In most of these patients, psychotherapeutic exploration revealed that this orientation was unverbalized until the therapy had clarified it and that it had existed prior to the first signs that were noted of the tumor. In their daily existence, these people had functioned, continued the routine work of their lives, gone on with their businesses and never believed that life could hold any satisfaction for them. Only the Dark Bridegroom could offer surcease from the otherwise endless necessity of working at the impossible. Each of them had followed in the footsteps of Sisyphus; rolling the stone constantly up the hill, knowing they could not reach the top, but having to keep on trying. Most of them had repressed the emotions connected with this despair and accepted their lives as they saw them with a stoic lack of bitterness or resentment.*

Menninger[5] has reported on three elements in the suicidal patient: the wish to die; the wish to kill; the wish to be killed. In the person in despair, there seems to be present only the first of these, the wish to die. Exploration revealed no evidence of the active components—those involving relationships with others—the wish to kill and the wish to be killed. There are simply not enough real cathexes to permit them.

It has been mentioned that the patient does not feel that he can have any hope of solving his problem in his proper person. This seems to be an important element. In his deep and wise exploration of this psychological problem, Kierkegaard,[6] speaking of "the disrelationship of despair," points out that to get rid of despair one must get rid of one's self for it is one's self that one despairs of. But to be rid of one's self is also a cause of despair since it means no longer to be one's self. It is this concept that the cancer patients advance again and again. They feel they can be themselves and be unloved and alone or they can get rid of

*I tell you, hopeless grief is passionless;
That only men incredulous of despair
Half-taught in anguish, through the midnight air
Beat upward to God's throne in loud access
of Shrieking and Reproach. Full desertness,
In souls as countries, lieth silent-bare
Under the blanching, vertical eye-glare
Of the absolute Heavens.

Grief—Elizabeth Barrett Browning[7]

themselves, be someone else and be loved. These appear to them to be the only two paths open.

One patient, in saying this, saw it as a conflict between her "individuality" and "popularity"—to be herself or to be loved. "And it's as if I have to have both food and water to live and I can only have one of them." To give up her "individuality," her own way of seeing and reaching to the world meant the loss of herself; to retain it meant to be alone.*

Early in therapy, this patient (a brilliant, highly-trained specialist in her field) had expressed a great deal of anxiety about being a "mediocrity," an everyday type of person with no special features who could be an ordinary part of her local suburban group. Exploration revealed that she knew she was unusual but that she was afraid of her own drives to become a "mediocrity" deliberately, to give up her special differences in order to try to win love and acceptance. Although she had much anxiety that she would do this, this particular patient was never able to accept the Faustian bargain.

Another patient, in his first session, told how he had always been an independent person who "never needed a pillow" in his life. The qualities of strength, competence, dominance and independence marked the central parts, the bone structure of his individuality, as he saw himself. This is what he was and had been. As the therapy progressed, however, it developed that he felt he could not be loved as himself, could only win fear and respect and that to gain the love he so desperately needed, he must become passive, dependent and weak. He could not do this and yet felt he could not gain what he needed without doing it. Expending more and more energy in a frenzied attempt to gain love through domination and control, an attempt he knew must fail and yet felt compelled to continue, he deeply wished only to die and thus be able to cease the struggle.

One patient had an intense drive, since childhood, to write poetry. Her view of herself and her reactions to the environment

*This is an important difference between how the neurotic and the patient in despair view change in themselves. The neurotic may not wish to change himself and may show major resistances, but it never occurs to him that if he changes he will be anyone but himself; that he will cease to exist as an individual. To the patient in despair, this appears to be the inevitable result. In his view, if he changes, he has annihilated himself. In this sense, his despair seems justified to him. He sees himself in the trap of having to exist in the present unbearable isolation or not existing at all.

were in this frame of reference. Her work was of very high quality and could easily have been published, but she never was able to show it to anyone or to send it to a publisher, as she felt it would reveal how different she was from everyone else and would cause her to be rejected by others. (After several months of therapy she—with much anxiety—showed some of her verse to the therapist who privately obtained a professional opinion of it. This corroborated his own impression that it was of very high caliber.)

This patient had married a writer and—for a brief time—the relationship had been positive and intense. He was beginning his career and felt confident of his future development. When it became apparent that *her* abilities were far greater than anything he could expect of his own potential, her writing became a real threat to him, and he withdrew emotionally from their relationship. With her acute artistic perception she realized that her early anxieties—about whether to be a poet *or* be loved—now seemed justified by reality.* She tried to give up her poetry, tried very hard to give up all of herself for him. The relationship, however, did not improve and presently she found herself unable either to write or to be loved, and was deeply despairing of any real satisfaction in her life.

Illustrations could be multiplied. In each of the patients some formulation of this was found. They felt that to gain what they needed to give meaning to their lives they must give up themselves and become something else. But to consider this solution was a perfectly logical reason for despair. To accomplish it—for any length of time—was impossible and, as could have been predicted, did not win the love they so desperately sought. Most of them had tried and succeeded for a shorter or longer period. Sooner or later the attempts broke down. During the attempts, their despair had, of course, been intensified.

The lack of faith in development also emerged as a previously nonverbalized belief. In the patients' perceptions, the future could not change the conditions which brought them so much emotional pain and anguish. Even if outside events so changed that the objective conditions they needed were present, they would have only the shadow, not the substance. Their basic lack of relation-

*She felt she either had to be a poet or *nothing*, not as a neurotic might view it, to be a poet or a housewife.

ship to objects was so great that the gap could not be really crossed.

(The neurotic or depressed patient may express similar sentiments, but, if one looks closely, they are made in connection with others. There is anger, hostility, love, jealousy behind them. That suicide, for example, is often an aggressive act is too well-known to need amplification here.*)

It is this basic life-orientation that emerged in the cancer patients during psychotherapy. Its verbalization came often as a surprise to the patients, followed swiftly by a realization that "this is how I always felt." Once this feeling had emerged into consciousness, the patient was often badly "flooded" by it for a long time. It kept reappearing in many forms and on many subjects until it could be finally worked through. This was an extremely painful time for the patients. Once, however, a more realistic orientation had replaced it, intelligent and constructive movement was possible in the patients' personalities and life-space.

As the illustrations given demonstrate, the despair was related only superficially to the cancer by the patients. Their fatal disease—all the patients studied knew their diagnosis and its usual prognosis—was seen as only "one more example" of the hopelessness of life for them. They felt that the despair long antedated the neoplasms and that their becoming fatally ill merely confirmed what they already believed. The problem of their unbearable existence was being solved for them by the cancer in a final, irrevocable getting rid of themselves. This was literally the solution they had always figuratively feared and yet felt was inescapable.

The despair did not seem to be a symptom of resistance. Rather, it appeared to the therapist as simply an uncovering of something already there; a making overt of what had been covert. In the control patients, depression sometimes appeared in the therapy. This seemed to arise for the usual reasons and would be worked through in terms of such dynamisms as reaction-formations against hostility.

Two problems which have arisen in this formulation are:

(1) In view of this orientation, why do the patients continue to go on with the routine of their daily existence?

(2) How can they relate to the therapist?

*In this connection, Martin Buber wrote: "Yet the man who straightforwardly hates is closer to relation than the man without hate or love."[9, p. 5]

The writer's answers to these questions are tentative and further research is needed for increased understanding. One reason that the patients "go on" in spite of their beliefs that they will accomplish nothing of real meaning seems to be because they view their activity as involved in the choice between being "themselves" and being "someone else." They seem to perceive only two possible paths. The first is to be and act according to their self-images, even though this is seen as leading only to continued rejection and isolation. The second is to give up themselves and earn affection and relatedness by acting in ways they feel as so ego-alien that they are totally self-destructive. They choose the first, although many have made transitory efforts to follow the second road, only to find that it increased their despair. In this connection, it is startling to observe how few cancer patients—even when they know and emotionally accept the fatal outcome—change their way of life and activity. One might expect that, faced with a sentence of death, they would attempt to have new experiences, fulfill old dreams, etc. This reaction is actually very rare. (Until the pain becomes overwhelming, even suicide is a rare entity. Perhaps the importance of relationships with others as a factor in the etiology of suicide has not elsewhere been so clearly demonstrated.)

The "either-or" view of the cancer patient seems to press him to continue his accustomed activities as long as this is physically possible. One difference between despair and depression is in this area. The depressed patient does *not* go on with his usual activities—the greater the depression, the greater the tendency to give them up. No matter how acute the despair, however, the routine activities of everyday life are maintained.

After the cancers have started, the patients, as just noted, maintain their old, "either-or" views as motivations to continue their lives as before; but there seems to be a difference between their attitudes before and after the appearance of the malignancies. Afterward, psychotherapy is generally acceptable to them; only in some cases was it before. One might hypothesize that—now that the choice of existence or nonexistence has been made for them by the disease process—psychic energy, formerly bound in this conflict is released. Only after the choosing is over, are they able to dimly perceive the possibility of the middle road which the therapist offers. It is this that seems to be the strongest link

between patient and therapist; the outstanding possibility that therapy offers. (It is known in social work that the best time to start therapy with juvenile delinquents is often at the point when they have just been committed to a treatment center. The recognition of the final nature of that solution seems to free them, for the first time, to consider whether there may be other solutions. A similar process appears to be operating in the cancer patients.)

For reasons discussed elsewhere,[10] it is essential that the psychotherapist who works with cancer patients present himself as an integral part of a medical treatment center. This serves also to make it easier for the patient to relate to him, the basic view being, "I am a person who co-operates with treatment."

In addition, the therapist is seen as a paradoxical but attracting figure. He relates to the patient whether the patient reciprocates or not. He insists—by his attitudes—that it is possible for the patient to find meaning and validity in his life-space. He reverses the experience that the patient feels he has had by believing that the patient can get more out of life by being more truly himself than he can by trying to adopt new personality characteristics. He lights and fans a spark of hope in the patient and in spite of the frequent hostility this arouses ("You tempt me to hope and then I'll only be hurt again and I can't take any more."), this is responded to in a positive manner. As one patient put it: "You're crazy, but I think you're crazy in a way that's good for me. Maybe some of it will rub off on me." In the deepest despair, is the memory of lost hope, and it is to this that the patient often seems to be relating.

In the following discussion, the writer will present some speculations and hypotheses about despair and its sources.

Discussion

In a research into the personality and emotional life history of over 300 cancer patients (including those who were studied in intensive psychotherapy), a specific type of life-history pattern emerged and seemed to have occurred far more frequently in the cancer patients than in the controls.* This pattern was as follows:

*The writer is not presenting any case histories or statistics illustrating this pattern in this paper. That has been done elsewhere.[11, 12] However, speaking generally, this life history pattern was observed in over 60 per cent of the writer's cancer patients and approximately 10 per cent of his controls.

Early in life, the self, the environment and the important others in it were so perceived that relationships were felt to be dangerous; to be invested in deeply only at the cost of much pain and rejection.*

No obvious neurosis or psychic disturbance occurred, but the individual's relationships with others were henceforth rather superficial. He held back emotionally, appearing to function well, but feeling isolated, different, and guilty about this difference.

Sometimes—almost invariably in the writer's cases in adolescence or early adulthood—an opportunity to relate was found which seemed relatively "safe" and which did not seem to mobilize guilt or anxiety. Usually slowly and cautiously, the individual moved into this relationship, experimented with it and finally accepted it. Into it, was poured all the need for warm and intense relating that had been unexpressed for years. This became the central focus of life, the *raison d'être*. Other relationships were maintained, but continued to be somewhat superficial.

For one reason or another, usually beyond the individual's control, this cathexis was eventually lost: A spouse died, children grew up and moved away, job retirement was enforced, etc.** (The length of time the cathexis was maintained varied in the writer's cases from one to 33 years.) Sometimes the despair became conscious for a short period after this and was suppressed. Efforts were generally made to find new relationships to replace the lost

*That specific *incidents* which would tend to encourage this type of orientation occur more frequently in the childhood of individuals who later develop cancer than they do in the childhood of individuals who do not, can be demonstrated statistically. Thus, Reznikoff[13] showed that the death of a sibling in childhood had occurred more often in his cancer patients than in his carefully equated, noncancerous controls. LeShan and Reznikoff[14] showed that, statistically speaking, their cancer subjects had had a shorter period of being the youngest child (with the consequent greater stress at the birth of the next youngest sibling) than had the cancer-free controls.

**That a higher cancer mortality rate exists in groups in which the members have more often lost a major relationship than in groups in which this has happened less often to the members, can be demonstrated statistically. Thus, LeShan and Worthington[15] chose a variety of social groups and showed that the greater the tendency for there to have been major cathexes lost by individuals within them, the higher the cancer mortality rate. Peller,[16] in his analysis of mortality rates from cancer of the colon, was able to show that the higher rate for widows (compared to married and single women) was not due to reproductive accomplishment or to social class, but was related to the loss of the husband per se.

one. The extent and intensity of these efforts appeared to vary greatly.*

It is the writer's impression that there is a general relationship between the length of time from the ending of the cathexis to the first signs of a tumor on the one hand, and the general rate of neoplastic development on the other. The shorter the period, the more rapid the development of the neoplasm. Thus, judging them by use of the framework of West, Cutler and Ellis,[17] patients in whom the tumor was diagnosed shortly after the loss of the cathexis (i.e., six months to two years) tended to be "fasts" (to have rapid tumor development). Those for whom this period was longer (two years to eight years) tended to be in the middle of the curve or to be "slows" (to have slow tumor development). In many cases, it was not possible to tell exactly when the cathexis was perceived to be lost as in the cases of loss when children grew up, changed their roles and became independent. The degree to which other cathexes filled the gap also seemed relevant here. From the patients' associations to the material of the despair theme, it appears to the writer as if this orientation took shape and solidity after the loss of the cathexis. Although the patients often believe that "this is how I always felt," the feeling seems to have been more a potentiality than a reality before this point in their lives. There had been pessimism before but apparently not the peculiar hopelessness of despair. It seemed to be the loss of the individual's central relationship that—superimposed upon the general personality structure—made the basic outlook finally solidify in this way.

It often appeared as if the patients were saying in effect, "I was right to be so pessimistic. This proves it. Nothing really good can happen to me, and if I allow myself to hope, it just leaves me open to more disappointment and anguish." Several of them

*Exactly what factors determine the extent of these reparative efforts is not clear. At this point, they can only be generally summed up as "past experience" and "other personality variables." However, in all the writer's patients, they sooner or later slackened off. (In several of the control patients whose life-histories—up to this point—had followed the pattern, the reparative attempts had either been successful or were still being continued with the subject expecting ultimate success.) The writer's patients continued to function adequately, to maintain their other, superficial roles and relationships, but with no zest or enjoyment in life. The general level of expended energy—both physical and psychic—dropped off to pre-cathexis levels, which were somewhat lower than the levels apparently maintained during the existence of the cathexis. Within periods of from six months to eight years after the loss of the major relationships, the first signs of neoplasms were noted.

verbalized their feelings in terms similar to this. On a deeper view, however, it became clear that the orientation was more than a response to disappointment and loss. It rather appeared to be a basic loss of faith in the ability of outside "objects," or of the external situation, to bring any positive feelings into existence. Literally the patient had given up hope of satisfying his needs through the use of anything outside himself and had no belief that he would develop into any state where the situation was different.*

Theoretically we might speculate that we are dealing here with a partial ego regression to a very early stage of development. To the stage when objects were first cathected to in a maneuver designed to ease internal stresses and bring about satiation and repletion. Otto Fenichel introduces his discussion of this maneuver as follows:

> The striving for discharge and relaxation, the direct expression of the constancy principle, is necessarily the older mechanism. The fact that external objects brought about the desired state of relaxed satisfaction introduced the complication that objects became longed for... The longing for objects thus began as a detour on the road to getting rid of them... This is at the point at which a contradiction of basic importance in human life arises, the contradiction between longing for complete relaxation and longing for objects (stimulus hunger).[19]

Obviously this phenomenon is an extremely early libidinal development. A regression past this point, to a loss of belief in the ability of objects to satisfy needs, would help to account for many of the special qualities of despair: for the lack of hope, the lack of cathexes, the bleakness, for what Martin Buber calls "I-IT" relations (as opposed to "I-THOU" relations) only.[9]

It would also account for the sense that the therapist develops in intensive psychotherapy with cancer patients, that psychosis is a real possibility if the therapy proceeds too rapidly. (This has emerged also in the study of projective test records of cancer patients.) As has been reported elsewhere,[5] this seems to be a real problem in such therapies.

Some remarks of Smith Ely Jelliffe lead one to speculate about the effects of such a regression upon the body. In his essay, "The Body Organs and Psychopathology," he points out that when

*"Patients with cancer, I believe, die from a negative state of stress so to speak. They die when they are overcome by a state of futility and hopelessness."[18]

libido gratification is blocked, sublimation becomes ineffective, and the repressed portion of the libido

> . . . pushes back to earlier stages of adaptation. The energy charge (cathexis) of the libido regresses.

What happens to the repressed libido and the repressing forces? In a crude sense it backfires or stalls. Here is where internal medicine becomes interested. If the repressing forces are of sufficient dynamic potential to push back the libido to those stages in the individual's development when isolated organs were limited autocracies, as they were in infancy when each organ sought its own gratification independent of the others, then the fat is in the fire.[20]

This is a provocative and stimulating hypothesis. Whether or not it is ultimately shown to have validity, there is reason to believe that the despair per se has physiological effects. Bellak[21] has reviewed the literature on the effects of psychological depression. If depression has such marked effects on body processes as he reports, one can assume that the much more intense state of despair has, at the very least, comparable effects. The more so as despair is a repressed emotion with the consequently greater effect on body processes than it would have if it could drain off consciously as does depression.*

Certainly no implication is intended in this presentation that psychological factors are the only ones of importance in the etiology of neoplasms. Cancer can apparently be produced by a wide variety of agents. In the subjects considered here, the writer is aware of the existence of no known physical carcinogens in the background. It is extremely probable that a very different psychodynamic picture would be found in a group of subjects who had been subjected to the action of such agents. There seems no question that certain physical agents can induce neoplastic devel-

*One can also approach despair from another side—the alienation and loneliness which characterize it. In the absence of knowledge of intervening variables, what kind of biological response do we believe that this kind of isolation leads to?

"In the last resort, we must begin to love in order that we may not fall ill, and must fall ill if, in consequence of frustration, we cannot love."[22] Thus Freud summed up his findings in this area. Findings similar to this were made by Durkheim[23] from a quite different approach. The evidence that isolation and the loss of ability to relate appear to bring self-destructive processes into play has been presented elsewhere by the present writer.[24] It is not feasible here to do more than point out that such evidence exists. Whether the apparent psychological isolation of the cancer patient is a factor in this kind of process will have to be left to future investigators and to increased knowledge of the psychophysiological interactions involved.

opment no matter what the emotional status of the individual involved.*

It is also quite reasonable to suppose that physical factors which predisposed them toward cancer may have existed in the writer's subjects independently of their psychological life histories. These may have taken many forms. There could be a physiological deviation which increased the likelihood of intense emotional disturbance resulting in cancerous development. There could have been a factor which made it impossible for the patients to master too intense quantities of emotional tension and thus predisposed them toward regression to a very early stage of libidinal development. In such a case, the very marked regression might have served as a trigger for the neoplasm (or, from another viewpoint, might have served to disrupt the body's cancer defense system). Other possibilities also exist. The existence of a common psychological factor in cancer patients *in no way* militates against the necessity for the existence also of common physiological and/or genetic factors. The probability that a previously existing, specific physiological factor may be a necessity in cancerous conditions, seems to be increased by the fact that the type of life history that the writer has observed in cancer patients occurs in many individuals who do not develop this disease. Although the "despair" has not (to the writer's knowledge) been observed elsewhere, this could certainly be accounted for by the fact that there is very little motivation for people with this orientation to go into psychotherapy; and it is only in such psychotherapeutic exploration that it would be likely to be delineated. Further, the type of emotional life history reported here may be characteristic only of patients in whom the neoplasms are of a fatal type. (All the writer's subjects were in this class.) It may be quite uncharacter-

*It is, however, entirely possible that the individual's *resistance* to the action of physical carcinogens is partially determined by emotional status. In this connection, it would seem of real value to examine individuals who have been exposed to such agents (i.e., the radium-dial painters) to see if emotional factors played a part in determining which of them developed malignancies and which did not.

istic in patients whose neoplasms would not, if left to themselves, rapidly proceed to a terminal state.*

* * *

Since the acceptance of this paper for publication, the author has realized that Greene et al., in a study of lymphomas and leukemias in women, have reported the prevalence of "helplessness and hopelessness" among their subjects.[26] This is apparently quite similar to the factor reported in this paper as "despair." Schmale has reported states of "helplessness" and of "hopelessness," which "... clearly antedated any evidence of disease," as common in his group of medically ill patients. He believes that these states "... may be related to increased biological vulnerability."[27] This further raises the question of whether the despair is typical of the cancer patient, of the cancer patient who will die of his illness, or of the individual who will develop a severe, somatic illness. Jores has lately suggested that his epidemiological studies appear to support the third of these hypotheses.[28] However, the problem is far from settled. From the data of the present study one can at least state that despair, as herein described, is typical of the cancer patient with a fatal cancer.

Conclusion

In the psychotherapeutic study of cancer patients, a specific type of basic emotional orientation was observed and named "despair." This consists of a deep belief that the individual can attain no satisfaction or meaning in his life and that, in spite of any efforts he may make, there is no hope of them in the future. This *Weltanschauung* appears to crystallize after a major traumatic event (the loss of the central cathexis) in an individual who has learned early in life to perceive relationships as dangerous and potentially painful. This major trauma occurs some time before the first tumor symptoms are noted. It emerges into consciousness

*A recent, extremely interesting study by Paloucek and Graham[25] appears to give evidence in this direction. They divided their patients with cancer of the cervix into two groups, equal as to stage of the disease and type of treatment. The first group (23 patients) had "a miserable childhood, a bitterly unhappy married life and a bleak, hopeless future, while the second group (26 patients) were average or higher in each of these categories." In the first group, 57 per cent (13 patients) showed a poor response to treatment. In the second group, 15 per cent (4 patients) showed a poor response. When questioned about their future, all women in the first group considered it to be "hopeless or totally unacceptable." Only four (15 per cent) of the women in the second group fell into this category.

only after an extended period of exploratory psychotherapy. Some hypotheses concerning the possible meanings of this orientation are presented.

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REFERENCES

1. Kowal, S. J.: Emotions as a cause of cancer; eighteenth and nineteenth century contributions. Psychoan. Rev., 42:217-227, 1955.
2. LeShan, L., and Worthington, R. E.: Personality as a factor in the pathogenesis of cancer. A review of the literature. Brit. J. Med. Psychol., 29:49-56, 1956.
3. Petschke, H.: Psychosomatische Faktoren und Neoplasien. Z. Psycho. Som. Med., 3:42-45, 1946.
4. LeShan, L.: Personality states as factors in the development of malignant disease: a critical review. J. Nat. Ca. Inst., 22:1-18, 1959.
5. LeShan, L., and Gassmann, M. L.: Some observations on psychotherapy with patients with neoplastic disease. Am. J. Psychother., 12:723-734, 1958.
6. Kierkegaard, S.: The sickness unto death. In: Fear and Trembling, and the Sickness Unto Death. Doubleday. New York. 1953.
7. Speare, M. E. (editor): The Pocket Book of Verse. Pocket Books. New York. 1940.
8. Menninger, K.: Man Against Himself. Harcourt, Brace. New York. 1938.
9. Buber, M.: I and Thou. T. and T. Clark. Edinburgh. 1932.
10. LeShan, L.: Some methodological problems in the study of the psychosomatic aspects of cancer. J. Gen. Psychol., 63, 309-317, 1960.
11. LeShan, L., and Worthington, R. E.: Some psychologic correlates of neoplastic disease: a preliminary report. J. Clin. Exper. Psychopathol., 16:281-288, 1955.
12. ——: Some recurrent life history patterns observed in patients with malignant disease. J.N.M.D., 124: 460-465, 1956.
13. Reznikoff, M.: Psychological factors in breast cancer. Psychosom. Med., 17:96-108, 1955.
14. LeShan, L., and Reznikoff, M.: A psychological factor apparently associated with neoplastic disease. J. Abnor. and Soc. Psychol., 60, 439-440, 1960.
15. LeShan, L., and Worthington, R. E.: Loss of cathexes as a common psychodynamic characteristic of cancer patients. An attempt at statistical validation of a clinical hypothesis. Psychol. Reports, 2:183-193, 1956.
16. Peller, S.: Cancer in Man. International Universities Press. New York. 1952.
17. Gengerelli, I. A., and Kirkner, F. J. (editors): The Psychological Variables in Human Cancer: A Symposium Presented at the Veterans Administration Hospital, Long Beach, Calif., October 23, 1953. University of California Press. Berkeley. 1954.
18. Hutschnecker, A. A.: Health and wholeness. Ohio State Med. J., 55:1091-1094, 1959.
19. Fenichel, O.: The Psychoanalytic Theory of Neurosis. P. 35. Norton. New York. 1945.
20. Jelliffe, S. E.: The body organs and psychopathology. In: Sketches in Psychosomatic Medicine. P. 78. Nervous and Mental Disease Monographs, No. 65. Nervous and Mental Disease Monographs. New York. 1939.

21. Bellak, L.: Manic-Depressive Psychoses and Allied Conditions. Grune & Stratton. New York. 1952.
22. Freud, S.: On narcissism. In: Collected Papers, Vol. 4. Hogarth. London. 1946.
23. Durkheim, E.: Suicide: A Study in Sociology. Free Press. Glencoe, Ill. 1951.
24. LeShan, L.: The safety-prone: an approach to the accident-free person. Psychiatry, 15, 465-468, 1952.
25. Paloucek, F. P., and Graham, J. B.: Precipitating factors in cancer of the cervix. Presented at Annual Conference of the American College of Surgeons. 1958.
26. Greene, W. A., Jr.; Young, L. E., and Swisher, S. N.: Psychological factors and reticulo-endothelial disease: II Observations on a group of women with lymphomas and leukemias. Psychosom. Med., 18:284-303, 1956.
27. Schmale, A. H., Jr.: Relation of separation and depression to disease. Psychosom. Med., 20:259-276, 1958.
28. Jores, A. H.: Psychologische Voraussetzungen des Todes Untersuchungen zum Pensionierungstod. Paper presented at the first meeting of the International Psychosomatic Cancer Research Study Group, August 12, 1960, at Amsterdam.

A REVIEW OF THE PSYCHOANALYTIC LITERATURE ON PASSIVITY

BY HENRY HARPER HART, M.D.

In reviewing some 60,000 pages of psychoanalytic literature during the past 16 years, the author was impressed by the frequency of the use of the term "passivity" and the almost complete absence of definition. He assumed, therefore, that its conventional meaning is known, clear and acceptable. In all languages, to be passive, means *to have something done to or for one,* and never to be the agent, doing something to others.

The earliest use of "passive" that the writer can find in the works of Freud is in his "Heredity and the Etiology of the Neuroses," in 1896, in which he observed "that a passive sexual experience before puberty was the specific etiology of hysteria."[1] He connected this with the preference in females for hysteria.[2] In "The Defense Neuro-Psychoses" he said:[3] "in all my cases of obsessional neurosis I have found a substratum of hysterical symptoms which can be traced back to a scene of sexual passivity of earlier date than the pleasurable activity." Freud returned to the active-passive antithesis in his discussion of the second pregenital phase or anal-sadistic organization:[4] "Here the opposition between two currents which run through all sexual life is already developed; they cannot yet be described as masculine and feminine, but only as active and passive. The activity is put into operation by the instinct for mastery through the agency of the somatic musculature; the organ which more than any other represents the passive sexual aim is the erotogenic mucous membrane of the anus. Both these currents have objects which however are not identical." Later in the same work[5] he noted the sexual pleasure which children derive from the sensation of passive movement; but, still further,[6] he wrote: "It is essential to understand clearly that the concepts 'masculine' and 'feminine' whose meaning seems so unambiguous to ordinary people are among the most confused that occur in science. It is possible to distinguish at least three uses. 'Masculine' and 'feminine' are used sometimes in the sense of activity and passivity, sometimes in a bilogogical, and sometimes again in a sociological sense ... Activity and its concomitant phenomena (more powerful muscular development, aggressiveness, greater intensity of libido) are as a rule linked with biological masculinity;

but they are not necessarily so, for there are animal species in which these qualities are on the contrary assigned to the female."

In 1915, in "Instincts and Their Vicissitudes"[7] Freud spoke of every instinct as a form of activity: If we speak of a "passive instinct," we can mean only an instinct whose aim is passive. He considered the "plausibile assumption" of Federn and Jekels[8] that the form and function of the organ determines the activity or passivity of the instinct's aim and confessed that: "The fusion of activity with masculinity, and passivity with femininity confronts us indeed as a biological fact, but it is by no means so invariably complete and exclusive as we are inclined to assume."[9]

At least three polarities, active-passive, masculine-feminine, and genital-pregenital, are here linked with the instinct-libido theory, according to aim, organ, and function. But confusion results. One wonders why the antithesis active-passive, which was so distinct in the pregenital phase should become less distinct in the genital phase. In 1919, Freud found that the problem became more complicated with masochism,[10] but "passivity is not the whole of masochism." In "The Economic Problem in Masochism,"[11] he traced moral masochism to the desire to be beaten by the father and to have passive relations with him. This passivity toward the man may be rejected by masculine narcissism[12] so that the wish for passive coitus with the father is distorted into fear of the wolf. In "Analysis, Terminable and Interminable,"[13] he showed how this may lead to a rejection of passivity to other men in favor of passivity to women. He does not explain what makes submission to a man more offensive to masculine narcissism, than submission to a woman to feminine narcissism. We find many women in our culture who are much more passive to mother figures but extremely competitive and aggressive with men. Could this depend simply on the position of the mother as the chief disciplinary and super-ego figure in the modern family?

In the *New Introductory Lectures,*[14] Freud finds that the girl's passivity to the father is limited to the abandonment of clitoris masturbation, but passivity in coitus and childbirth are attributed to the genital stage of the libido.[15] The assumption of her biological and physiological functions with the genital stage of the libido is considered a passive phenomenon. In the "History of an Infantile Neurosis,"[16] the man expresses his passivity through the gastro-intestinal tract. What about the woman? What do her

gastro-intestinal disturbances express? We have no reason to assume that women have fewer gastro-intestinal complaints than men or that the pelvic sympathetic innervation is fundamentally different in the two sexes.

The commonest antithesis found in the literature on passivity is that of passivity-aggression. Menninger points out[17] that being killed is the extreme of submissiveness, as killing is the extreme of aggression; and it may be supposed that he would agree with Jesus that they often go together. "He that liveth by the sword shall perish by the sword" is perhaps the first characterization of the passive-aggressive personality. Alexander[18] observes that the stronger the primary aggression against the father, the greater the passive female reaction. Many patients reported in the literature show extremes of aggressiveness and passivity. For example, Wilson[19] describes a woman lawyer who changed in transference from hostile castrative to passive dependent, infantile behavior. Lorand[20] writes about a man who allowed his wife to dominate him in order not "to burst out with anger and kill someone."

Sterba[21] describes a bank employee of 27, passive and feminine, who lived on milk and chocolate for 15 months, was afflicted with pruritus ani, premature ejaculation, and constipation, as well as a fear of hurting somebody. Bergler[22] mentions an impotent man of "unconscious passive, feminine type" who boxed his wife's ears, after being tortured by her, and, when his self-reproaches became severe, developed déjà vue. Deutsch[23] tells of a woman who dominated her husband completely because she had to defend herself against a dangerous, passive, masochistic surrender to a previous brutal lover. Alexander[24] finds a peptic ulcer expressing the passive dependent wishes of a "tough baby" gangster who was outwardly truculent. Menninger[25] finds aggressive tendencies in schizophrenia to be a secondary defensive reaction against the patient's "passive homosexual desires," and Kubie[26] sees angry defiance and fearful submission, self-vindication and guilt in the same symptom. Zilboorg[27] finds such a blend in the belief in Hell. Jones[28] states that complaisant yielding is the best imaginable mask for hostility, and Glover[29] feels that passive submissive amiability is less important than the hostile tendencies it cloaks.

Alexander[30] observes that females thwarted in their passive feminine desires may develop aggressive, castrative features. The "collapsing-controlling" woman of our era is a familiar example

of the *passive-aggressive personality,* which shows this oscillation. We need to explore what this "aggressiveness" really amounts to. Most Caspar Milquetoasts greatly overestimate their dangerousness. Bergler[31] finds that obsessives are flattered when one mentions their aggression, but are angry and depressed when the underlying passivity is revealed. One would expect that if guilt made aggressive persons passive, the recognition of this passivity would bring relief from the burden of guilt. Apparently *shame over passive dependent wishes is more potent dynamically than guilt over aggression.* Pertinent here, is the fact that the so-called aggression seldom effectively masters reality or produces social leadership, but is primitive, childish, unintegrated, poorly sustained and wild. Hence, when we refer to aggression, we must differentiate between a mature and integrated form, and an immature and uncontrollable form. The so-called passive-aggressive personality seems to be equipped with the latter form.

The occurrence of *passive-aggressive swings in normal childhood* confirms the suspicion that an immature ego structure finds passivity its only escape from rage, and vice versa. Such limitation of alternatives, like a harp with two strings, may underlie the need for simple causes, quick magical solutions, and impatient, unsustained reflection in a complex multidetermined reality. Thus the *passive-aggressive antithesis,* like the *sado-masochistic* and the *manic-depressive,* presents *diphasic reactions characteristic of the poorly equipped ego.*

Equally emphasized in psychoanalytic literature, is the equation of passivity with femininity, despite the warnings of Freud. From the ego standpoint, there is almost as wide a range of helplessness and resourcefulness in the female as in the male sex. Annie Reich,[32] who considers extreme submissiveness to be as perverse in women as it is in men, demonstrates that women brought up in an all-female, protective environment are unusually passive, helpless, dependent creatures.[32] She finds the submissive woman's helplessness to be rooted in the childish fixation to the mother. One of these women had been nursed for three years at her mother's breast, and another wanted to bite off her husband's penis when her marriage began to fail. There were two submissive women who imagined that during coitus the woman got and kept the penis—the very fantasy that disturbs the potency of pas-

sive men. Oral and anal fantasies and fixations seem constant in the passive of both sexes.

Even though, as Deutsch[34] observes, the sweetest, loveliest woman of the "most passive feminine type" can become fierce and aggressive when she suffers a narcissistic injury, even though the lioness is said to be more dangerous than the lion when her cubs are threatened, there is still plenty of evidence that woman's activity is differently focused and expressed than is man's, so that she gives the impression of passivity. Cannon[35] notes that elderly female cats submit more calmly to restraint than do young male cats. Moulton[36] notes that progesterone dominance is associated with passive receptive ideas and pregnancy fantasies. Benedek, Hoskins, and Carmichael have shown the male hormone testosterone increases sexual desire. Certainly one cannot exclude a hormonal factor in the restlessness, mobility, competitiveness, speeding, automobile accidents, crime and violence in our male adolescents during their phase of greatest sexual drive. Male mammals are generally more active than female. The suggestion of Deutsch[37] that the change from external to internal fecundation has brought this about indicates also that the gestation process is more successful with less mobility.

But estrogenic hormones do not produce passivity, they produce maternal activity. Activity is not a male monopoly. In the writer's opinion the person who comes closest to defining passivity in the psychoanalytic literature is Nunberg. He finds it enormously difficult to define what is activity and what is passivity.[38] "Some kind of inertia comes to the mind," he says, "when we attempt to define it, tardiness, a tendency to submission, as if man were trying to perpetuate his infantile dependence."[39] He runs into the difficulty of analogizing masculinity with activity and femininity with passivity,[40] but describes a passive woman who expected everything to be done for her. "Whatever the essence of passivity may be," he muses, "clinical observation shows that femininity in the man is represented by the passive aims of his sexual instincts."[41] Nunberg concludes that activity and passivity form a problem that cannot be solved by psychoanalysis alone because it is a biological problem.[42]

Reik[43] says that the *original wish of woman was to be loved, and not to love;* and Klein[44] believes that women are more dependent on the love and opinion of others than are men. She finds that

in the latency period the girl is "passive and maternal" but that too great docility tends to subservience.[45] Reich[32] also insists that there *are normal limits to feminine passivity beyond which it is pathological ego weakness.*

Freud, as we have seen, finds no evidence of feminine passivity in pure culture. He declares[46] that the sexual aims of the little girl toward her mother are both active and passive. She identifies with the male in wanting to actively penetrate the mother as father does and to impregnate her. Deutsch[47] notes a sadistic phallic attitude toward the mother coincident with passivity to the father, and this simultaneous opposition of active with passive wishes is mentioned by Fenichel.[48] Deutsch[49] finds the little girl, in her play with dolls, is active, not passive, and Deutsch insists[50] that tomboyishness is not only normal, but more desirable from the standpoint of health, than the conventional withdrawal into domesticity. Hermann[51] declares that the "passive woman" is really an ideal constructed from the neurotic anxiety of men. Lampl de Groot[52] agrees with this in saying the subordination of active to passive libido strivings is seldom complete in woman and that the "purely feminine woman" is purely narcissistic. She does not love, but allows herself to be loved. Lampl de Groot finds normality in a balance of activity with passivity. She finds that extreme passivity in a woman is based on extreme narcissistic insult and a feeling of genital inferiority, whereas a girl who is not so hurt is able to enjoy her femininity. Deutsch[53] confirms this, remarking that the completely passive girl never sublimates her fantasies and fails to develop her active femininity. She concludes that the passive, feminine woman shows infantilism of body structure, voice, gesture, associated with dependence, ego immaturity and pride in ignorance so as to sustain this dependence.[54]

Considerable feminine passivity has been attributed by some authors to the vagina, which Deutsch[55] describes as an "oral sucking organ," deriving its passivity from oral reinforcement. The knowledge of the passive role of the vagina is considered by Müller-Braunschweig[56] as the basis of the pronounced masochism of infantile femininity. Deutsch,[57] however, describes vaginismus as sometimes powerful enough to produce penis captivus; and hence the vagina, like the mouth, does not seem to serve aims that are always passive.

Let us consider first the oral theory of vaginal passivity. Both oral and vaginal orifices are lined by the same type of epithelium, are lubricated by the same type of glands, and depend on what is put into them for their muscular and secretory activity. Spasm and anesthesia of the pharynx can have the same unconscious meaning as spasm and anesthesia of the vagina. The two orifices are likewise susceptible to the same lesions. However, the mouth is an organ of mastery and of aggression, supplied by a cranial nerve, the first to be myelinized, and hence the chief executive organ of the infantile ego. Only in myth, phobia and dream, does the vagina take on a prehensile or devouring significance. Gingival changes occur during menstruation, and vaginal contractions[58] have been reported during happy suckling. Brierley says[59] that stimulation during oral frustration is likely to give vaginal activity a "biting character," but "stimulation at the climax of sucking pleasure may establish positively toned sucking impulses." Alice Balint[60] described a little girl who at four masturbated with one finger in her mouth and one in her vagina, saying, "I am feeding my bottom." One orally aggressive manic-depressive woman masturbated in similar fashion, and also inserted a champagne bottle neck into her vagina. Little girls have been known to insert carrots, marbles, egg shells, etc., into this passage, which is supposed to be unknown to them. Weiss[61] described a girl who had a vaginal sensation during an attack of globus hystericus, when she bit the analyst's finger. A further indication of the unconscious displacement of vaginal to oral symptomatology was observed by the author,[62] who found 20 women to be the sole complainants, out of a thousand random psychiatric patients, of "bad taste in the mouth." All of the 20 had oral sepsis and sexual frigidity.

But what does this prove? Two erogenous zones, the mouth and the vagina, are interchangeable in fantasy, dream, sensation, and perversion, and have similar functions. But this displaceability is true for all erogenous zones. Hendrick,[63] for example, described a passive man who thought of his penis as a sucking organ and not a penetrative one. What seems to be taken for granted, is that a deep oral or vaginal hunger is a sign of passivity, whereas it may be the stimulus to activity. If mouth and vagina were so interchangeable as to be the basis of passivity, we would expect a greater incidence of peptic ulcer in women than in men, since there would be much more frustration of vaginal hunger and

certainly just as much oral frustration. Every article on peptic ulcer stresses the repression of "passive oral longings." Why should men repress such longings more than women? Are we to attribute the greater incidence of peptic ulcer in men to strain or shame—to a greater condemnation of passivity?

What is confusing in the literature is the attempt to prove the "passivity" of one organ in terms of the passivity of another, when it seems to be more evident that both organs can serve passive and active aims. Even the sucking of the infant, says Glover,[64] has both an active and a passive phase. The beak of the bird, the fang of the serpent, the jaw of the shark, and the oratory of man have seldom suggested passivity. Complete oral gratification in the human race is rare, since the consumption of cigarettes, chewing gum, alcohol and betel nut is widespread. Civilized man when his aggression, either social or intellectual, is frustrated, reaches for his cigarette or his pipe. Hunger, whether in the carnivore or in man, is a prime impulse to action. If one calls this oral activity regressive, then it can hardly be pathological, since it is universal.

There is much evidence to suggest that when oral cravings become wide and profound, the need to regress to the breast is very strong. That we all need such rhythmical regression is suggested by Lewin,[65] who equates sleep with the satiated infant sleeping at mother's breast. Oral characters seem always to be at the breast. Glover[66] described an alcoholic shoe fetishist who said that nice people gave him a sweet taste in the mouth. while those who angered him made him grind his teeth. Even ideas seemed to "come into his mouth," not into his mind. Eisendorfer[67] wrote about a passive dependent woman who had been brought up in an all female environment, and not weaned until she was three. She had frequent dreams of eating with mother, and her outstanding traits were submissiveness, dependence and passivity. Alexander[68] considers that the passive homosexual relation to the father found in every male's analysis is a repetition of the "passive" suckling situation.

Passive regressive oral cravings have been found in alcoholics, and in persons with speech disorders, reading disabilities, nail biting, obesity, anorexia nervosa, vomiting, peptic ulcer, and melancholia. Clearly, other factors in these disorders must be responsible for such a wide choice of expression. "Regression" like

"passivity" needs much more evaluation, both qualitative and quantitative, if its disorganizing power is to be appreciated. Stone[69] mentions weaning trauma in peptic ulcer likened by Garma to "a wound of separation from the mother." Persons with such ills are seized by the recurrent and unconscious need to regress to the suckling stage, which lessens as it becomes conscious. But oral characters are not always regressive or passive. Mark Twain, Sigmund Freud, and Winston Churchill were all great consumers of cigars and masters of the word. They were initiators and creators. All men of literary genius have been voracious readers, with a hunger that led to mastery, instead of helpless dependence. Balzac, as he wrote his hundred novels, drank 50,000 cups of coffee. If this is passivity, then all alcoholics are novelists. Evidently more than a persistent oral craving is needed to make a great writer. Certainly every stammerer does not become a Demosthenes. What we must differentiate more sharply is the oral aggressive enjoyment of the world, and its mastery through sublimation from the more regressive passive suckling, with its retreat from reality.

All of this, of course, leads to mother. It is not a mere accident that hundreds of millions of people worship a Madonna with the infant at her bosom. Mother symbolizes bliss, Nirvana, peace, the all-enveloping, protecting and nurturing refuge of the fetus, the sleeping infant and the helpless adult. If father represents the mastery of reality, mother represents the pleasure principle, the flight from reality, the everflowing breast. No human mother could ever satisfy such persistent longings, so she must be idealized. Even civilization itself, as it progresses, becomes maternal.

Ribble[70] notes that passivity and daydreaming are common in persons who were their mothers' sole libidinal outlets. Freud[71] observes that the first sexual experiences of the child in relation to the mother are passive. Eisendorfer[72] traces the intense oral passivity of a girl who was raised only by females, and who listened to stories her mother read to her when she was in bed for two years with tuberculosis. Saul[73] describes a young man whose passivity was fostered by identification with a mother who kept him in curls until he was six and encouraged him to be hostile to his masculine father. Parenthetically, it should be noted here that the character of the mother is decisive in conditioning this passivity. Anna Freud[74] finds the male homosexual enjoying the

active and passive sides of a mother-son relationship. Not only is the infant the passive recipient of mother's fondling, nursing, bathing, rubbing, touching, playfulness and cathartic activities; but when it is sick, it receives even more love and attention, exaggerated if the overprotective mother is compensating for guilt over rejection of the child. The mother's importance to herself is often enhanced by the child's illness. Many mothers derive a sense of magical omnipotence in cultivating protracted dependence from illness, at the expense of active play, reality testing, competition and mastery.

Such mothers invariably give the child the conviction that the world is dangerous, and that they will always need mother. One dainty musician, suffering from impotence and many oral and nasal symptoms, who fantasied having a vagina while a large woman with a penis lay on top of him, actually had a large overprotective mother who prevented him from playing with "rough boys," dressed him up like a girl, played in bed with him sexually, took obsessive care of his bowels, and caressed his genitals in the bath. His chief sexual fantasy was of being a tiny creature appended to and caressed by a large man or woman. His political ideas revolved about a maternal, protective state.

According to Wilhelm Reich,[75] a passive feminine character in a man is invariably due to identification with the mother or excessive strictness in the father. Passivity does not appear to characterize men whose mothers were wise and objective enough to balance love with frustration and who were never overindulgent. In such men, identification with the mother, which occurs in all men, seems to strengthen the ego instead of weaken it. The basic ego strength of the mother is a factor not sufficiently emphasized in psychoanalytic literature.

Why is it that identification with the mother seems to be such an important factor in male homosexuality? Whether in males or females, homosexuality seems always associated with profound dependence, oral fixation and passivity. Freud,[76] Anna Freud,[74] and Deutsch[77] all consider that the attachment to the original active and passive role of mother and child may continue in homosexuality. Freud[78] says that mother-fixated homosexuals choose male love objects of the same ages that they themselves were when mother loved them. Traumatic weaning followed by the denial of the disappointing breast is stressed by some authors.

Alexander[79] believes that passive homosexuality may remain unconscious and become displaced to the mother instead of the father. Saul[80] reports a homosexual boy who tried to deny his strong passive transference, but had oral aggressive, cannibalistic dreams. Needles[81] notes a homosexual man in analysis who, despite warning, got married during a passive dependent transference. Bergler[82] describes the passive character who accuses himself of homosexual tendencies, yet does not have any real need for perversion with his own sex, but is sexually aroused only by women. Thus it would appear as if identification with the mother is not the only factor in homosexuality, but that there must be deep hatred, with the desire to burlesque the woman and render her unnecessary.

Turning to the problem of homosexuality, one finds in Bychowski's study[83] of the ego in homosexuals a constant, infantile pattern of ego functioning. One of his cases was a man who always felt timid, childish and feminine in the presence of masculine men. The homosexual ego is unstable, without a normal feeling of self, but with a feeling of emptiness and hollowness. Bychowski[84] suggests that mutual fellatio represents the little child being suckled by the phallic mother, as well as the attempt to incorporate the power of the other man, to strengthen one's own ego. One homosexual described by Bychowski was vulnerable to any neglect because his mother lived only for him, and hence should know even when he awoke, since mother and he were one. Nunberg[85] describes a passive woman who expected the analyst to know her every thought. Bychowski indicates the weakness of the masculine ego ideal, contributing to the feeling of sham and emptiness which impels the homosexual to project his masculinity on other men. He adds that the weak ego of the actual mother is decisive for this ego-weakness. The homosexual shuns women because he sees his own ego-weakness mirrored in them. Bychowski feels that even the aggressive homosexual, who provokes seduction, favors a philosophy of power because of this weakened ego feeling. The inability to identify with the father shown by the homosexual is hidden in the pre-Oedipal history of the little boy.

As one surveys the literature on the passive-aggressive personality, with its ambivalence, and apparent lack of choice, and in addition the ego weakness of the homosexual, together with the oral dependence factor in passivity, one is impelled more and

more to seek the nucleus of passivity in the nature and structure of the ego. Payne[86] sees passivity as a manifestation of a weak ego, deficient in innate resources; and Deutsch[87] sees passivity in the ego as resulting from inadequate defenses. Federn[88] holds that psychic and bodily ego feelings can be both active and passive and remarks[89] that the psychic ego feelings in dreams are more passive than active. Freud[9] implies an elastic shift from either state to the other when he declares that the ego is passive in receiving stimuli but active in reacting to them. Complete passivity, says Kardiner,[90] means that the world is permitted to overwhelm one; and Winterstein and Bergler[91] see the ego as passive under super-ego attacks.

Thus the ego can be overwhelmed by reality, the super-ego and the id, and can be considered liable to passivity to all three. The child, originally passively seduced, tries to control the sexual impulses by initiating seduction, but often the sexual impulse cannot be induced at will. For the weak ego, pregenital impulses, oral, anal and urethral, may be too powerful for the ego to be other than the passive spectator of the conflict between id and super-ego. Heilbrunn[92] finds that ingratiating, submissive traits of character can be traced to this overwhelming of the ego by instinctive forces. This throws light on the passive-aggressive personality, who, like Uriah Heep, turns from obsequious submission to ruthless arrogance. Gero[93] says that the submissive attitude of the male masochistic character is usually "ego-syntonic," whereas the repressed, passive anal, or self-castrative impulses are "ego-alien." Something in the ego is able to deflect whatever is narcissistically the more injurious by accepting something else that is less so. Submission to moral demands carries a dignity wanting in anal perversion, and the most humiliating tortures can be endured if they are for a noble cause. This dignity preserves the ego's integration and equilibrium, and hence it becomes the first target of the brainwashing and sadism of totalitarian concentration camps, so that the ego is deprived of any nobility in suffering. Fenichel[94] draws attention to the unrealized strength of the ego in actively producing experiences that it considers itself subjected to passively. All paranoiacs seem to have this capacity, whence they seem to derive some of their grandeur.

To understand the weakness of the passive ego, identification, both as a defense and as a growth process, must be understood.

This is still far from being achieved. Hendrick[95] speaks of the passive identification caused by the unpreparedness of the ego in dealing with castration anxiety. To identify with the enemy is a sign of helpless submission, and since most unconscious identification requires little effort on the part of the ego, being an extension of oral incorporation, it carries with it the indiscriminate stamp of immaturity. Active and mature identification involves effort, conscious emulation and love, with selection and objectivity. What determines whether the identification is passive or active, would seem to be the capacity to choose, which resides in the resourcefulness of the ego and not in the reality situation. Gero[96] points out that the choice of a passive defense is still an ego activity, and the ego may be either active or passive toward its own passivity. Castration fear may provoke activity in some and passivity in others, depending on the innate wealth or poverty of alternatives.

Nunberg[97] suggests that by carrying the repetition compulsion from the id into the ego, we can transform a passive experience into an active one, but one must ask, can all egos do this? Does the ego transform a passive experience into an active one merely by becoming aware of it? Awareness may enable us to avoid what we cannot control. The woman who arranges a "passive seduction" is not a passive ego overwhelmed by a situation over which she has no choice, but may be initiating a series of events that may bring her a kingdom or fortune. Her "passivity" is chosen, deliberate, conscious and introductory.

When Bergler[98] reflects that "man's whole psychic life is a desperate attempt to escape from passivity," one infers that it is a passivity over which the ego has no conscious choice. Thus the inability to choose would seem to constitute the trauma of childhood which evokes castration anxiety, impressing the ego with its own helplessness. Such a trauma may lead to the inability to tolerate frustration passively, and may be based on an incapacity to deflect an id impulse into an ego mastery.

Here is where anxiety enters into the complex problem of passivity. Is it the cause or the result of passivity? Anxiety is usually accepted as the sign that the ego is reaching the limit of its adaptability. If we are right in considering the "passive ego" as weak in choices, then we can assume *a priori* that the more passive the ego, the greater the anxiety. We are all familiar with the

anxiety that besets people with few choices. However, a profound anxiety in childhood invariably makes thoughtful choosing difficult. Bonaparte[99] suggests that the part played by activity in contrast to passivity in enduring a trauma may determine the readiness to anxiety. "Passivity" is obviously used here in the sense of helplessness, and not chosen inactivity. Keiser[100] observes that fantasies during the sexual act, in both male and female patients, indicate that anxieties center about passivity.

Since passivity can be enjoyable, and can be fought for with as much zest as activity, the arousal of anxiety makes sense only if "passivity" is equated with ego helplessness. Children welcome the passive enjoyment of being bathed, fed, clothed, caressed and even evacuated by devoted mothers or nurses, but recoil with anxiety from the equally passive situation with dentist or barber. The child has no knowledge of how much or little its body integrity will be threatened by the latter, and certainly has little choice or control. As Helene Deutsch[101] suggests, the fear of narcosis is due to the fear of being at the mercy of arbitrary, external powers, when something terrible will be done to one. *Passivity is equated with the loss of all ego function, i.e., helplessness.* Hysterical patients who resort to syncope, paralysis or coma, paroxysms or trances may express passive wishes, not to provoke anxiety, but as an escape from it. Indeed, activity can be as much a source of anxiety as passivity, if the latter can be measured and controlled. For example, Eisenbud[102] describes a sexually impotent man who went into a panic on being given an injection of male hormone, which he feared would take away his infantile passivity.

When the ego wants to be protected and supported, it reacts with anxiety to any challenge or demand for activity. This is partly from fear of the unfamiliar, because to be active means to adventure into the new and the unpredictable. The victims of Nazi sadism felt less helpless when they knew beforehand what tortures the S.S. had in store for them. Anxiety before the unknown, the uncontrollable and unpredictable is inseparable from castration anxiety and can be cultivated by overprotection by others or one's self.

It has been found in this survey that identification with the mother is an important factor in the passivity of the homosexual, and that the mother identified with is seldom a wise and strong person. All kinds of unconscious identification with weak, frustra-

ting, and frustrated, contradictory and unstable parents enter the fabric of the schizoid ego, and are to be found in alcoholics, homosexuals, psychopaths and compulsive neurotics. Ample evidence of the disintegrating effect of contradictory identifications is to be found in the literature. Some writers conclude that identification itself is a sign of passivity and helplessness. Herold[103] speaks of *two types of identification, outward and active, inner and passive;* and Deutsch[104] thinks that woman's deeply rooted passivity with regard to life's processes, outside of the reproductive function, disposes her to identification.

In a previous article, the author[105] drew attention to the evolution of identification from the indiscriminate to the discriminate, and from the unconscious to the conscious. This process is seen here to apply also to "passivity." Maturing of the ego means wider choices, greater selectivity, wider consciousnes. Herold's "outward and active" identification probably is of this variety. An identification that is selective is analogous to a passivity that is chosen by the ego, and hence is not a threat, as of something ego-alien. Reik[106] says that women enjoy the power of the man in their very surrender to him, a process seen at work in the male homosexual; and Müller[107] declares that behind the woman's identification with a man is her "direct wish to be overpowered and ravished." This really seems to be the enjoyment of helplessness. Why then is there not more anxiety? Could the "ecstasy of surrender" be another way of deriving delight from giving the sexual partner delight? The orgasm itself is a sort of surrender, and hence a great source of anxiety to the weak ego. To give pleasure to another is not necessarily to surrender, but may even be a means of seductive power. The most seductive women have never been the most helpless, while, conversely, the women who are the least experienced in sex are commonly the most helpless and anxious about it. This lays open for question *whether there is really much identification in the sex act at all.* Homosexuals shun women because they fear the ego weakness which they themselves share. It is the awareness of the mystery of sexual difference, so exciting at puberty, that contributes to the romance of new sexual adventure. The normal man finds woman's femininity entrancing, because different. He does not need to incorporate strength.

What is of concern here is really the form and quality of the identification, whether active or "passive," selective or nonselec-

tive, in relation to its usefulness in building ego strength. Not all great men have had great sons. Weak, pusillanimous fathers have, however, often generated weak, pusillanimous sons. Apparently *it is easier to identify with weakness than strength.* Certainly such identification requires little effort. Identification with the inferior qualities of the parent has both such a self-destructive and such a revengeful aspect as to make one wonder if it is as indiscriminate as it appears. A well-organized ego cannot, however, be constructed out of revenge. This is exemplified by the identifications of schizophrenics, which are ineffectual, contradictory, accidental, haphazard and usually self-defeating. They are regressive and punitive, requiring little effort or selection. Like dreams, they represent expressions of an infantile wish.

This review has been a sampling of the literature on passivity. Actually few articles have been written upon it, though the term is in constant use. There are many other aspects of passivity that the scope of this paper prevents exploring. Thus masochism has been avoided, because it is too complicated a problem in itself to explain passivity. Frustration as a source of passivity has not been touched, and might have been rewarding. The role of thought in passivity, touched on elsewhere, has here been avoided. The writer has stressed the mother-child relationship, without indicating how important the father-child relationship may be, even if it is secondary. The nature and evolution of the super-ego might have been explored, as well as recognized cultural patterns, such as identification with the machine. All these remaining aspects of the problem indicate the role of this article as a modest beginning of what the writer hopes will be subsequent important research on a profoundly significant factor in human adaptation.

Summary and Conclusion

In summary and conclusion, the review of the psychoanalytic literature on passivity can lead to the following suggestions and observations:

1. As definition is consistently avoided, it must be assumed that passivity means to the analyst what it means etymologically and conventionally, namely, the antithesis of activity, or the expectation of having things done to or for one.

2. Though passivity is everywhere found to be antithetic to aggression, the latter is not too clearly defined and is so often

involved in diphasic alternation with passivity as to suggest a diphasic entity. The passive-aggressive personality thus turns out to be a poorly integrated, relatively unresourceful, indiscriminate ego-organization whose oscillations may be akin to the sado-masochistic and manic-depressive diphasic oscillation. The aggression supposed to be antithetic to the passivity actually contributes to it by its noneffectual, primitive, explosive character.

3. "Feminine" and "passive" are everywhere equated in the literature, as if synonymous, yet maternal activity which is essentially feminine is not passive. The very passive woman does not love, but wishes to be loved, and seems to be as infantile as the correspondingly passive man. As Freud pointed out, the terms masculine and feminine are still as confused as any in science. In mammals, the female is generally less active than the male.

4. Submission or passivity to the mother instead of the father seems less offensive to both masculine and feminine narcissism, possibly because in the modern family the mother is the dominant parent and authority figure who does things to and for one. This is particularly so during the formative years of childhood, when passivity to the mother is conditioned.

5. Fluctuations and oscillations of activity and passivity toward either parent are apparently normal for both boy and girl during the successive stages of childhood. Although knowledge of these fluctuations would help us in the understanding of the super-ego, not much seems to have been written about them.

6. Passivity, so often identified with the blissful Nirvana of infantile or fetal sleep, and with sucking at the mother's breast, becomes paradoxically a source of danger against which "masculine narcissism" builds up its defenses, as if the ego were aware that such regression could not be controlled. How does the ego know that its regressive tendencies might become irreversible?

7. Anxiety over passivity (choicelessness) is as marked in the female as in the male, and *extreme passivity or submissiveness is an ego-abnormality in either sex.*

8. We can distinguish between two types of passivity, as between two types of identification: (a) expressive of helpless choicelessness, (b) that in which the ego makes a conscious, adaptative choice. This seems to explain why a passive, dependent role gives security to some and anxiety to others.

9. Identification with the mother is generally conceded to determine passivity, and especially homosexual passivity. Yet not all men who identify with their mothers become homosexuals. Apparently the strength or weakness of the mother's ego has something to do with this. Not enough attention has been given to the mother's personality in determining the nature of passivity.

10. A sharp distinction between oral-passive and oral-active seems wanting in the literature, for orality is generally given a passive connotation, when it is also our most important zone of mastery.

11. The alimentary tract, which is so often regarded as the organ expressing passive wishes, has the same autonomic innervation in the two sexes, and the same frequency of disturbances; yet for some reason or other, passive wishes in the male are expressed through its dysfunction more often than in the female, i.e., peptic ulcer. There is a mystery here that seems to need clearing up. It may be involved with social and super-ego expectations.

12. Passivity, defined as the wish to have things done to and for one, is the manifestation of an ego that is weak in techniques of mastery, weak in integrative capacity, impoverished in choice of defenses, having few alternatives available to meet traumatic or frustrating situations and prone, therefore, to regression to infantile levels of functioning. Whether this ego weakness is inherited or conditioned by parents with similar weakness remains to be discovered, but prolonged dependence upon and identification with a weak, clinging, protective mother is almost indispensable for passivity in all its various clinical manifestations.

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REFERENCES

1. Freud, Sigmund: Heredity and the etiology of the neuroses. (1896.) Collected Papers. Vol. I. P. 149. Hogarth. London. 1924 to 1948. Basic Books. New York. 1959.
2. ——: Ibid., p. 153.
3. ——: The defense neuro-psychoses. (1896.) Collected Papers. Vol. I. P. 162.
4. ——: Three Essays on the Theory of Sexuality. (1905.) Complete Psychological Works of Sigmund Freud. Vol. VII. P. 198. Hogarth. London. 1933.
5. ——: Ibid., p. 201.
6. ——: Ibid., p. 219.
7. ——: Instincts and their vicissitudes. (1915.) Collected Papers. Vol. IV. P. 65.
8. ——: Ibid., p. 76.

9. ——: Ibid., p. 77.
10. ——: A child is being beaten. (1919.) Collected Papers. Vol. II. P. 189.
11. ——: The economic problem in masochism. (1924.) Collected Papers. Vol. II. P. 266.
12. ——: History of an infantile neurosis. (1918.) Collected Papers. Vol. III. Pp. 594-5.
13. ——: Analysis, terminable and interminable. (1937.) Collected Papers. Vol. V. P. 357.
14. ——: New Introductory Lectures on Psychoanalysis. P. 174. Norton. New York. 1933.
15. ——: Op. cit., ref. 11, p. 261.
16. ——: Op. cit., ref. 12, p. 557.
17. Menninger, Karl A.: Psychoanalytic aspects of suicide. Int. J. Psychoan., XIV: 382, 1933.
18. Alexander, Franz: Relation of structural and instinctual conflicts. Psychoan. Quart., II; 187, 1933.
19. Wilson, George W.: The transition from organ neuroses to conversion hysteria. Int. J. Psychoan., XIX: 27, 1938.
20. Lorand, Sandor: Role of the female penis phantasy in male character formation. Int. J. Psychoan., XX: 172, 1939.
21. Sterba, Richard: The dynamics of the dissolution of the transference resistance. Psychoan. Quart., IX: 365, 1940.
22. Bergler, Edmund: A contribution to the psychoanalysis of déjà vue. Psychoan. Quart., XI: 170, 1942.
23. Deutsch, Helene: The Psychology of Women. Vol. II, p. 344. Grune & Stratton. New York. 1944.
24. Alexander, Franz: Op. cit., ref. 18, p. 191.
25. Menninger, William C.: Characterological and symptomatic expression related to the anal phase of psychosexual development. Psychoan. Quart., XII: 184, 1943.
26. Kubie, Lawrence S.: The repetitive core of neurosis. Psychoan. Quart., X: 32, 1941.
27. Zilboorg, Gregory: The sense of reality. Psychoan. Quart., X: 195, 1941.
28. Jones, Ernest: The phallic phase. Int. J. Psychoan., XIV: 13, 1933.
29. Glover, Edward: Lectures on technique in psychoanalysis. Int. J. Psychoan., VIII: 328, 1927.
30. Alexander, Franz: Psychological factors in gastro-intestinal disturbance. Psychoan. Quart., III: 526, 1934.
31. Bergler, Edmund: The Basic Neurosis, Oral Regression and Psychic Masochism. P. 164. Grune & Stratton. New York. 1949.
32. Reich, Annie: A contribution to the psychoanalysis of extreme submissiveness in women. Psychoan. Quart., IX: 470, 1940.
33. ——: Ibid., p. 474.
34. Deutsch, Helene: Op. cit., ref. 23, Vol. I, p. 197.
35. Cannon, Walter B.: Bodily Changes in Pain, Hunger, Fear and Rage. P. 13. Appleton. New York. 1929.
36. Moulton, Ruth: Psychosomatic study of anorexia nervosa. Psychosom. Med., I: 63, 1942.
37. Deutsch, Helene: Op. cit., ref. 23, Vol. I, p. 220.

38. Nunberg, Herman: Circumcision and problems of bisexuality. Int. J. Psychoan., XXVIII: 161, 1947.
39. ——: Ibid., p. 164.
40. ——: Ibid., p. 165.
41. ——: Ibid., p. 167.
42. ——: Ibid., p. 168.
43. Reik, Theodore: The Psychology of Sexual Relations. P. 133. Farrar and Rinehart. New York. 1945.
44. Klein, Melanie: Psychoanalysis of Children. P. 264. Norton. New York. 1932.
45. ——: Ibid., p. 296.
46. Freud, Sigmund: Concerning the sexuality of woman. Psychoan. Quart., I: 202, 1932.
47. Deutsch, Helene: On female homosexuality. Psychoan. Quart., I: 503, 1932.
48. Fenichel, Otto: Outline of clinical psychoanalysis. Psychoan. Quart., I: 18, 1932.
49. Deutsch, Helene: Homosexuality in women. Int. J. Psychoan., XIV: 49, 1938.
50. ——: Op. cit., ref. 23, Vol. I, p. 18.
51. Hermann, Imre: The use of the term "active" in the definition of masculinity. Int. J. Psychoan., XVI: 220, 1935.
52. Lampl de Groot, Jeanne: Problems of femininity. Psychoan. Quart., II: 513, 1938.
53. Deutsch, Helene: Op. cit., ref. 23, Vol. I, p. 143.
54. ——: Ibid., p. 215.
55. ——: The psychology of women in relation to the functions of reproduction. Int. J. Psychoan., VI: 408, 1925.
56. Muller-Braunschweig, Carl: The genesis of the feminine super ego. Int. J. Psychoan., VII: 359, 1926.
57. Deutsch, Helene: Op. cit., ref. 23, Vol. II, p. 83.
58. Brierley, Marjorie: Specific determinants in feminine development. Int. J. Psychoan., XVII: 165, 1936.
59. ——: Ibid., p. 168.
60. Balint, Alice: Identification. In: Year Book of Psychoanalysis. Vol. I, p. 319. S. Lorand, editor, International Universities Press. New York. 1945.
61. Weiss, Edoardo: Agoraphobia and its relation to hysterical attacks and to traumas. Int. J. Psychoan., XVI: 63, 1935.
62. Hart, Henry Harper: Bad taste (cacogeusia). Arch. Neurol. and Psychiat., 39: 9, 1938.
63. Hendrick, Ives: Ego development and certain character problems. Psychoan. Quart., V: 322, 1936.
64. Glover, Edward: Notes on oral character formation. Int. J. Psychoan., VI: 135, 1925.
65. Lewin, Bertram D.: Psychoanalysis of Elation. P. 83. Norton. New York. 1950.
66. Glover, Edward: Notes on an unusual form of perversion. Int. J. Psychoan., VIII: 14, 1927.
67. Eisendorfer, Arnold: The clinical significance of the single parent relationship in women. Psychoan. Quart., XII: 228, 1943.
68. Alexander, Franz: A metapsychological description of the process of cure. Int. J. Psychoan., VI: 30, 1925.
69. Stone, Leo: Transference sleep in a neurosis with duodenal ulcer. Int. J. Psychoan., XXVIII: 23, 1947.
70. Ribble, Margaret A.: The Rights of Infants. P. 109. Columbia University Press. New York. 1944.

71. Freud, Sigmund: Female sexuality. Int. J. Psychoan., XIII: 291, 1932.
72. Eisendorfer, Arnold: Op. cit., ref. 67, p. 224.
73. Saul, Leon J.: Some observations on a form of projection. Psychoan. Quart., XVI: 476, 1947.
74. Freud, Anna: Ego and Its Mechanisms of Defence. P. 146. Hogarth. London. 1937.
75. Reich, Wilhelm: The characterological mastery of the Oedipus complex. Int. J. Psychoan., XII: 461, 1931.
76. Freud, Sigmund: Op. cit., ref. 14, p. 178.
77. Deutsch, Helene: Motherhood and sexuality. Psychoan. Quart., II: 478, 1933.
78. Freud, Sigmund: Leonardo da Vinci and a Memory of His Childhood. P. 64. Moffat Yard Company. New York and London. 1916.
79. Alexander, Franz: Psychoanalysis of the Total Personality. P. 159. Nervous and Mental Disease Publishing Company Monograph No. 57. New York. 1930.
80. Saul, Leon J.: Psychogenic factors in the etiology of the common cold and related symptoms. Int. J. Psychoan., XIX: 459, 1938.
81. Needles, William: Stigmata occurring in the course of psychoanalysis. Psychoan. Quart., XII: 31, 1943.
82. Bergler, Edmund: Op. cit., ref. 31, p. 219.
83. Bychowski, Gustav: The ego of the homosexual. Int. J. Psychoan., XXVI: 114, 1945.
84. ——: Ibid., p. 118.
85. Nunberg, Herman: Op. cit., ref, 38, p. 166.
86. Payne, Sylvia M.: Some observations on the ego development of the fetishist. Int. J. Psychoan., XX: 166, 1939.
87. Deutsch, Helene: Some forms of emotional disturbance and their relationship to schizophrenia. Psychoan. Quart., XI: 316, 1942.
88. Federn, Paul: The ego feeling in dreams, psychoanalytic feeling in dreams. Psychoan. Quart., I: 515, 1932.
89. ——: Ibid., p. 532.
90. Kardiner, Abram: Traumatic Neuroses of War. P. 183. Hoeber. New York. 1941.
91. Winterstein, Alfred and Bergler, Edmund: The psychology of pathos. Int. J. Psychoan., XVI: 424, 1935.
92. Heilbrunn, Gert: Psychodynamic aspects of epilepsy. Psychoan. Quart., XIX: 156, 1950.
93. Gero, George: The concept of defense. Psychoan. Quart., XX: 569, 1951.
94. Fenichel, Otto: Problems of psychoanalytic technique. Psychoan. Quart., X: 35, 1941.
95. Hendrick, Ives: Pre-genital anxiety in a passive feminine character. Psychoan. Quart., II: 90, 1933.
96. Gero, George: Defenses in symptom formation. J. Am. Psychoan. Assn., I: 90, 1953.
97. Nunberg, Herman: Symposium on the theory of the therapeutic results of psychoanalysis. Int. J. Psychoan., XVIII: 167, 1937.
98. Bergler, Edmund: Op. cit., ref. 31, p. 60.
99. Bonaparte, Marie: A lion hunter's dream. Psychoan. Quart., XVI: 9, 1947.
100. Keiser, Sylvan: The psychopathology of orgasm. Psychoan. Quart., XVI: 390, 1947.
101. Deutsch, Helene: Op. cit., ref. 23, p. 246.
102. Eisenbud, Jule: Telepathy and problems of psychoanalysis. Psychoan. Quart., XV: 75, 1946.

103. Herold, Carl M.: A controversy about technique. Psychoan. Quart., VIII: 238, 1939.
104. Deutsch, Helene: Op. cit., ref. 23, p. 130.
105. Hart, Henry Harper: Problems of identification. PSYCHIAT. QUART., 21: 11, 1947.
106. Reik, Theodore: Masochism in Modern Man. P. 183. Farrar and Rinehart. New York. 1941.
107. Müller, Josine: A contribution to the problem of libidinal development of the genital phase in girls. Int. J. Psychoan., XIII: 367, 1932.

THE INFLUENCE OF SOCIAL VARIABLES, TREATMENT METHODS, AND ADMINISTRATIVE FACTORS ON MENTAL HOSPITAL ADMISSION RATES

BY HENRY B. ADAMS, Ph.D.

It is a well-documented fact that over-all rates of admission to mental hospitals in the United States have been rising in recent decades.[1] In some quarters this increase has been interpreted as a sign that the amount of mental illness in modern society is increasing. And certain contemporary American social trends, notably urbanization, industrialization, and the "breakdown of family life," often thought to accompany these changes, have frequently been viewed as causes.

But it is also a fact that rates of admission, particularly to public mental hospitals, vary widely from state to state. Many instances can be mentioned where adjoining states that are very much alike from an economic, social, and cultural standpoint show startling differences when rates of admissions to their mental institutions are compared. Differences of this nature pose serious questions for those who would interpret hospital admission statistics as an index of the incidence of mental illness in society at large.

Is such an interpretation valid? In surveying the literature, one gains the impression that the answer is often assumed to be in the affirmative. A recent study of the extent of mental disorders in the United States contains the statement that "the rate of first admissions to long-term mental hospitals has long been used as an index of the incidence of the more serious mental disorders,"[1, p. 10] along with the observation that an extensive literature has been published concerning the characteristics of such admissions, particularly admissions to state hospitals.

In another recent survey dealing with definitions of mental health and mental illness used by research workers, Scott[2] noted that six different kinds of definitions of mental illness had appeared in the literature. These included (1) exposure to psychiatric treatment, (2) social maladjustment, (3) psychiatric diagnosis, (4) subjective unhappiness, (5) objective psychological symptoms, and (6) failure of positive adaptation. Scott also noted that "the most frequently used operational definition of mental illness, at

least in terms of the number of studies employing it, is simply the fact of a person's being under psychiatric treatment. And this definition is usually restricted to hospital treatment rather than out-patient service. Nearly all the ecological studies . . . and most of the studies correlating mental illness with demographic characteristics . . .use this as a criterion."[2, pp. 29-30]

In view of the many published studies which tend to equate hospital admission statistics with the incidence of mental illness in the general population, it seemed appropriate to analyze these admission statistics more closely, especially those for state hospitals. Such an inquiry would serve to clarify the kinds of interpretations which could legitimately be made from such data.

With these considerations in mind, a series of related investigations of factors often thought to influence hospital admission rates was conducted. The findings, which are set forth in this paper, include (1) the consistency of mental hospital admission rates from year to year, (2) the range of differences between states, (3) relationships between admission rates, rates of discharge, and other indices of patient movement in hospitals, (4) the influence of three major social variables on admission rates, (5) the effects on both discharges and admissions of introducing a new treatment, the tranquilizing drugs, and (6) a comparison of admission and patient-turnover rates in various types of mental institutions.

Data and Sources

The analysis was based entirely on official census figures and similar published material. Descriptions and sources of data used in the analysis follow:

1. *Admissions.* Data on admissions to public (state, county, and city) hospitals for the prolonged care of the mentally ill were used for the analysis. Original figures broken down by individual states were obtained from *Mental Health Statistics, Current Reports*[3] for the years 1950 through 1955. The institutions covered by these reports accounted for almost 90 per cent of all resident patients in prolonged-care mental hospitals in those years, although these institutions had smaller proportions of the total admissions. This group of institutions was chosen primarily because statistics from state, city, and county prolonged-care hospitals on admissions and other types of patient movement were most amenable to the methods employed in the present analysis. Since "public" mental hos-

pitals serve well-defined geographical areas (states, cities, and counties), statistical data for these institutions can be more readily related to population figures and other social characteristics of the areas they serve than would be the case for other types of institutions, such as veterans' and private hospitals. However, admissions to other types of mental hospitals did come in for some study, using data from the census volume *Patients in Mental Institutions,* 1950 and 1951.

2. *Discharges.* Figures on discharges, like those on admissions, were taken from *Mental Health Statistics, Current Reports,*[3] for the years 1950 through 1955. Data were also obtained from the same sources on deaths and resident patients, as described under 3 and 4.

3. *Deaths.* Deaths were computed as the number of resident patients who died in hospitals during each year.

4. *Resident Patients.* Figures for the average daily resident patient population were computed by averaging the number of resident patients in the respective hospitals at the beginning and end of each year.

5. *Population.* Population figures for individual states were obtained from United States census reports,[5] estimating the civilian population of each state as of July 1 of each year from 1950 through 1955. Population was the denominator term in several of the indices used in the analysis.

6. *Urbanization.* The index of urbanization was the percentage of the population of each state classified as urban according to 1950 census figures, as set forth in the *World Almanac.*[6]

7. *Income.* Per capita income was used as a measure of the relative financial resources of each state. Figures on per capita income for individual states covering the years from 1950 through 1955 were also taken from the *World Almanac.*[6, 7] Income data for all the years during this period were averaged together, and the average for each state was used in the analysis.

8. *Aged Population.* This figure, taken from 1950 census figures given in *Health and Demography,*[8] is the percentage of the population of each state aged 65 and over. Since age-specific rates of admissions to mental hospitals are highest in the older age groups, it was thought that the percentage of elderly persons in the population of each state would be significantly related to admission rates.

Results and Discussion

Consistency of Admission Rates

One aspect of hospital admission statistics which has received little comment in the literature is the remarkable consistency of admission rates from year to year. Table 1 shows rates per 100,000 population of first admissions and all admissions (including readmissions but excluding transfers) to public prolonged-care mental hospitals in the United States from 1950 to 1955. The range of year-to-year variation was rather small, particularly in the case of first admissions. The first admission rate for the highest year of the 1950-1955 period was only 5.4 per cent greater than for the lowest year.

First admission and readmission rates are highly correlated. Taking a representative year for this period, a correlation of .788 was found between first admission and readmission rates for 1951. Total admission rates, i.e., first admission plus readmission rates, correlated .981 with first admission rates and .895 with readmission rates for that year. Since the definitions of "first admission" and "readmission" vary from state to state, and since correlations based on all admissions would seem to be in close agreement with those based on first admissions only, the writer's analysis of admission rates was based on total admissions.

Although Table 1 clearly illustrates the relative year-to-year consistency of admission rates for the nation as a whole, this does not eliminate the possibility of wide variations in individual states from year to year which cancelled one another out in the nation-

Table 1. Rates of Admission to Public* Mental Hospitals in the United States for the Prolonged Care of the Mentally Ill, 1950 through 1955

Year	First Admission Rate**	Total Admission Rate** (Excluding Transfers)
1950	72.8	97.3
1951	72.0	97.0
1952	74.3	102.5
1953	75.9	104.8
1954	74.6	105.1
1955	73.6	107.1

*This definition includes state, city, and county mental hospitals, but excludes Veterans Administration hospitals and temporary-care hospitals under public control.

**Number of admissions in each category per 100,000 estimated civilian population as of July 1 of each year. Source of admission figures, *Mental Health Statistics, Current Reports.*[3]

wide totals. However, if there were wide annual fluctuations of this type, they would show up in a correlational analysis. High correlations between successive years would indicate stable, consistent rates of admission in individual states, whereas low correlations would point toward the opposite conclusion.

Table 2. Intercorrelations of Rates of Admission to Mental Hospitals Between Selected Years and Between Single Years and the 1950-1955 Average

Years	r*
1950 and 1951	.930
1950 and 1955	.775
1950 and 1950-1955	.899
1951 and 1950-1955	.920
1955 and 1950-1955	.952

*All correlation coefficients are significant at well beyond the .001 level.

A correlational analysis investigated this possibility, the results of which are presented in Table 2. Correlations between certain individual years and correlations of these individual years with the average 1950-1955 admission rate were all very high, each being statistically significant at the .001 level. The correlation of .775 between 1950 and 1955 admission rates indicates that in general individual states maintained fairly consistent rates of admission over this period. This consistency is all the more significant if one recalls that some widely heralded new treatments, notably the tranquilizing drugs, were introduced during the 1950-1955 period, with pronounced effects on patient movement in and out of mental hospitals.

This finding implies that conclusions based on an analysis of admission data for any year during the 1950-1955 period are applicable for the entire period and probably for other recent periods as well, at least for this group of institutions. It is true that, over longer periods, admission rates have shown a steadily rising trend. But this trend apparently shows little responsiveness to short-term or year-to-year fluctuations. Whatever the factors are that have caused this steady long-term rise, their over-all effects seem relatively slow, gradual, and cumulative in nature.

Variations Between States

A second major but rarely discussed aspect of hospital admission rates is the wide range of variation between states.* Admis-

*The comparisons also include the District of Columbia.

sion rates in the highest-ranking states are several times those of the lowest, and as was noted before, these wide differences tend to perpetuate themselves.

In 1950, total admission rates varied from a low of 34.7 per 100,000 population in New Mexico to a high of 202.2 in the District of Columbia. The rate for the highest state was six times that of the lowest. While the extremes were not quite so great in 1955, the highest ranking state that year had an admission rate of 172.1, about four times the corresponding rate of 44.5 for the lowest state. Taking average admission rates over the entire 1950-1955 period, the average annual admission rate for Florida, which ranked lowest, was 46.4, about a fourth the average of 179.8 in New Hampshire, the top-ranking state.

Although rates of admissions to mental hospitals have long been interpreted as a measure of the incidence of the more serious mental disorders in society, comparisons between individual states raise serious doubts about the tenability of any such interpretation. It seems unlikely, for example, that the "true" incidence of mental illness in New Hampshire was four times as great as in Florida during that period.

But variations between states on other indices of patient movement are even greater. Table 3 shows the range of variation in admissions, discharges, deaths in hospitals, and resident patients per 100,000 population for the year 1951. The ranges, medians, means, and standard deviations of all four of these indices are given. On each index the figure for the highest ranking state was many times that of the lowest. The index of discharges in the highest state was six times that of the lowest, for deaths in hospitals it was nearly eight times greater, and for resident patients the index for the highest state was over five times as large as the index of the lowest. Such wide differences, all of which may be of a relatively enduring nature, probably reflect a variety of long-established social, legal, and administrative practices which differ from state to state. A careful, detailed study of these practices and the philosophies underlying them would be necessary to learn just how much they influence patient movement, but there is no question that their over-all effects on every index of patient movement can be formidable indeed.

Table 3. Range of Variation Between States (and District of Columbia) on Four Indices of Patient Movement in Public Prolonged-Care Mental Hospitals for the Year 1951

Indices*	Highest State	Lowest State	Median	Mean	S.D.
Admissions	189.2	37.7	90.0	92.7	38.3
100,000 Population	(R.I.)	(Kan.)			
Discharges	121.2	21.2	58.3	64.7	29.0
100,000 Population	(Ariz.)	(Fla.)			
Deaths in Hospitals	62.3	8.3	24.5	26.1	11.8
100,000 Population	(N.H.)	(N.M.)			
Resident Patients	879.4	162.6	305.3	319.2	119.9
100,000 Population	(D.C.)	(N.M.)			

*Description of Indices:

Admissions per 100,000 *Population.* The total number of patients admitted (including both first admissions and readmissions but excluding transfers) during the year 1951 to public (state, county, and city) hospitals for the prolonged care of the mentally ill per 100,000 civilian population for the respective states estimated as of July 1, 1951.

Discharges per 100,000 *Population.* Number of patients discharged in 1951 from public prolonged-care mental hospitals per 100,000 civilian population.

Deaths in Hospitals per 100,000 *Population.* Number of persons who died in 1951 while resident patients in public prolonged-care mental hospitals, per 100,000 civilian population.

Resident Patients per 100,000 *Population.* Number of average daily resident patients in public prolonged-care mental hospitals during the year 1951 per 100,000 civilian population.

Source: *Mental Health Statistics, Current Reports.*[3]

Interrelationships Between Indices of Patient Movement

In Table 4, the first column shows the correlations of 1951 admission rates with discharges, deaths in hospitals, and resident patients per 100,000 population. All three correlation coefficients were rather large, each being significant at the .001 level.*

The relationship of admissions to deaths and discharges seems obvious enough: deaths and discharges of previously hospitalized patients make space available for admitting new patients. The correlation of the admission rate with the resident patient rate

*Since a common denominator term was used for all four indices, the possibility of spuriously high correlation coefficients resulting form the common denominator was carefully investigated. It was found that the denominator term was not significantly correlated with any of the four indices, and that partialing out this source of variation did not alter any of the zero-order correlations significantly.

Table 4. Intercorrelations Between Four Indices of Patient Movement Based on 1951 Data*

	Indices	(1)	(2)	(3)	(4)
(1)	Admissions / 100,000 Population	..	..	..	..
(2)	Discharges / 100,000 Population	.886	..	..	..
(3)	Deaths in Hospitals / 100,000 Population	.806	.622	..	..
(4)	Resident Patients / 100,000 Population	.688	.518	.840	..

Multiple correlation $R_{1 \cdot 234} = .946$.

*All correlations were statistically significant at the .001 level.

requires a word of explanation. Since most public mental hospitals are kept filled most of the time and many of them have long waiting lists, the number of resident patients in these institutions closely approximates the number of hospital beds available. (Census figures on mental hospital beds were not available for 1951.) Hence, there was a substantial correlation between resident patient rate and total admission rate.

Indices of discharges, deaths in hospitals, and resident patients were also highly intercorrelated and, as Table 4 indicates, all of these intercorrelations were significant at the .001 level.* Since the discharge, death, and resident patient indices were so highly intercorrelated, a multiple correlation was computed to determine the joint relationship of these three variables to the admission rate. A multiple R of .946 was obtained. Such a high degree of relationship indicates that almost all the range of variation between states in rates of admission to public mental hospitals can be accounted for in terms of (1) the number of hospital beds available and (2) the rate at which deaths and discharges create space for new admissions. It follows that any factor which tends to increase the number of discharges or deaths in hospitals would tend to increase the number of new admissions. Some of the consequences of this observation will be noted later.

*Since a common denominator term was used for all four indices, the possibility of spuriously high correlation coefficients resulting from the common denominator was carefully investigated. It was found that the denominator term was not significantly correlated with any of the four indices, and that partialing out this source of variation did not alter any of the zero-order correlations significantly.

Admission Rates and Social Factors

In the literature on social psychiatry, a number of social factors have been mentioned as contributing either to the incidence of mental illness in the general population or to the availability of hospital facilities for treating those who show serious emotional disorders. Out of a number of relevant social factors, three were selected for study as most likely to exert a significant influence on hospital admission rates. These three are income, urbanization, and age of the population.

Income was selected on the grounds that states with higher per capita incomes would have more funds for mental hospitals, as well as other social services. States with higher incomes would, therefore, tend to have higher admission rates, other factors being equal. Urbanization was selected because of the widely prevailing belief that urban society is inherently more stressful and hence more conducive to the development of mental disorders than rural society. If this is true, greater urbanization should be associated with higher rates of admission to mental hospitals, particularly after the effects of other relevant variables have been partialed out. The age variable was selected because it is well established that age-specific rates of admission to mental hospitals climb steeply with advancing age, being highest in the group aged 65 and over.[1, 4] Consequently, the percentage of the population in each state aged 65 and over should theoretically be correlated with admission rate.

Table 5 shows the results of this analysis. The average 1950-1955 admission rate was positively related to all three social variables. The correlations of admission rate with income and urbanization were both significant at the .05 level. However, urbanization and per capita income were highly correlated ($r=.812$); the most urbanized states had the greatest wealth. When the effects of income differences between states were held constant by means of partial correlation, the net relationship between urbanization and rates of admission to mental hospitals dropped to nearly zero. It would appear that differences between states in rates of admission to psychiatric hospitals are more a function of ability to pay than of urbanization. These results are consistent with the findings of a recent survey by Leacock which concluded that "urban living per se is not more conducive to mental illness than rural living," and that "urban hospitalization rates are not consistently

Table 5. Intercorrelations Between Three Social Variables and Average 1950-1955 Rates of Admission to Public Mental Hospitals by States

	Admissions[a]	Income[b]	Urbanization[c]		Admissions[a]
Income[b]	.359*	..	..	Mean	103.4
Urbanization[c]	.316*	.812**	..	Median	98.2
Aged Population[d] ..	.264	.297*	.210	S.D.	36.5
				Range	46.4 — 179.8 (Fla.) (N.H.)

Partial correlation of admissions and urbanization with per capita income held constant=.045

Multiple correlation of admissions with combination of income and aged population=.397*

*Correlation coefficient significant at .05 level.

**Correlation coefficient significant at .01 level.

[a] *Admissions.* Average number of patients admitted to public prolonged-care mental hospitals per 100,000 civilian population during the 1950-1955 period.

[b] *Income.* Average per capita income by states for the years 1950 through 1955.

[c] *Urbanization.* The percentage of the population in the respective states classed as urban by the United States Census of 1950.

[d] *Aged Population.* The percentages of the population in each state aged 65 and over in 1950.

Sources: References 3, 6, 7, and 8.

higher than rural rates in different countries and in different parts of the United States."[9, p.336]

The percentage of the population aged 65 and over was positively correlated with the admission rate, but the correlation was so low that it fell short of statistical significance. (There was a significant but low positive correlation of the percentage of the population over 65 with per capita income.) In view of the great differences in rates of hospitalization of the elderly compared with the younger age groups for the country as a whole, it was surprising to find how little of the wide range of variation between states in admission rates could be accounted for by this factor.

When the joint effects on hospital admission rates of both income and percentage of the population over 65 were evaluated by means of multiple correlation, a multiple R of .397 was obtained. While this correlation was significant at the .05 level, it was not very large. Even though these two variables do have a measurable influence on rates of admission to mental hospitals, they fall far short of accounting for all the variance.

The multiple R of .397 between admission rate and the combination of two important social factors is to be contrasted with the

multiple correlation of .946 between admissions and the combination of discharge, death, and resident-patient indices. It seems likely that variations between states in admission rates are more adequately explained in terms of differing administrative policies in the hospitals themselves than by the social characteristics of the areas served by these institutions. It is true that varying administrative practices may indirectly mirror certain social characteristics of individual states, but the relationship of these social characteristics to differences in hospital admission rates is far less direct than the relationship of admission rates to the official policies governing admissions and discharges in public institutions.

Changes in Admission Rates Following Introduction of Tranquilizing Drugs

The close relationship between discharge and admission rates is illustrated by comparisons before and after the advent of tranquilizing drugs. The tranquilizers were introduced into public mental hospitals on a wide scale in the years between 1950 and 1955. They were hailed as a major improvement in treatment methods, particularly on the chronic wards of state hospitals. Glowing statements were made about results achieved with patients long regarded as hopeless.

How did the introduction of tranquilizers affect indices of patient movement? The upper half of Table 6 shows that admissions, discharges, deaths in hospitals, and resident patients all increased

Table 6. Changes in Patient Movement in Public Prolonged-Care Mental Hospitals in the United States 1950 to 1955

Year	Number of Admissions	Number of Discharges	Deaths in Hospitals	Resident Patients
1950	146,194	87,659	41,215	505,419
1955	173,864	115,930	44,280	554,592
Change	+ 27,670	+ 28,271	+ 3,065	+ 49,173
Percentage Change	+ 18.9	+ 31.0	+ 7.4	+ 9.7

Year	Rates per 100,000 Population as of the Years 1950 and 1955 Admissions	Discharges	Deaths	Patients
1950	97.3	58.3	27.4	336.4
1955	107.1	71.4	27.3	341.8
Change	+ 9.8	+13.1	— 0.1	+ 5.4
Percentage Change	+ 10.1	+22.5	— 0.4	+ 1.6

Sources: References 3 and 5.

from 1950 to 1955. The number of discharges in 1955 was 31 per cent greater, presumably reflecting the efficacy of the new drugs. The percentage increase in discharges was far greater than the percentage increases for the other three indices.

However, the population of the country also grew from 1950 to 1955. When figures on patient movement are related to population in those years, a different picture emerges, as shown in the lower half of Table 6. Deaths in hospitals and resident patients per 100,000 population remained virtually unchanged. But admissions and discharges per 100,000 population rose substantially from 1950 to 1955, the percentage increases being 10.1 and 22.5, respectively. The number of resident patients, and presumably the number of hospital beds, increased at about the same rate as the general population. Because of the greater number of hospitalized resident patients, there were correspondingly more deaths in hospitals, but once again the increase was roughly proportionate to the growth of population from 1950 to 1955. Only in admissions and discharges, did the increase substantially outstrip the growth of population.

It seems especially noteworthy that the numerical increase in discharges was almost exactly identical to the numerical increase in admissions, both being about 28,000. This finding bears out conclusions derived from the correlational analysis showing the close relationship of admission and discharge rates. If it is legitimate to attribute the increase in discharges to the use of tranquilizing drugs, then it would be just as legitimate to say that the increase in admissions was due at least indirectly to the same cause.

This example demonstrates that changes in rates of admission to public mental hospitals, far from being pure measures of changes in the incidence of mental illness in society, can instead reflect results of better treatment procedures. New methods in treatment can hasten the recovery and discharge of previously hospitalized patients, thereby making it possible for more individuals to receive treatment with the same hospital facilities. However, improved treatment methods certainly do not increase the incidence of mental disorders in the population, even if they do result in rising hospital admission rates. The fallacy of using the number of persons exposed to hospital treatment as a measure

of the incidence of mental disorders, even those of the most serious and incapacitating types, is clearly demonstrated by this example.

Admissions and Patients in Various Types of Hospitals

Since admissions to state hospitals have come in for the most extensive study in the published literature, it is pertinent to compare figures on these institutions with other types of prolonged-care hospitals. Table 7 shows that in 1951 state hospitals accounted for 85 per cent of resident patients in all the hospitals reported in the 1951 hospital census. The county and city hospitals, which were included in the totals for public mental hospitals, accounted for an additional 3.9 per cent of all resident patients. Thus, the public mental hospitals had 88.9 per cent of the resident patients but accounted for only 57.7 per cent of the admissions in 1951.

The comparison with veterans' hospitals and private hospitals brings out some notable differences. Veterans' hospitals, with only 8.7 per cent of the resident patients, had 17.2 per cent of the admissions, reflecting more rapid rates of patient movement. In the case of private hospitals, the contrasts are even more extreme. Although they had only 2.4 per cent of the resident patients in 1951, private hospitals accounted for 25.1 per cent of the admissions.

Two implications of these data particularly deserve mention. One has to do with inferences as to the nature and extent of mental illness that are based on state hospitals exclusively. Obviously, any such inferences have much room for error, since state hospitals account for scarcely more than half the total number of admis-

Table 7. Admissions During the Year and Resident Patients in Prolonged-Care Mental Hospitals of Various Types at the End of the Year 1951

Type of Hospital	Admissions			Resident Patients		
	Number	Per cent		Number	Per cent	
State Hospitals	141,583	55.8	57.7	497,013	85.0	88.9
County and City Hospitals	4,893	1.9		22,525	3.9	
Veterans' Hospitals	43,540	17.2		50,624	8.7	
Private Hospitals	63,743	25.1		14,293	2.4	
Totals	253,759	100.0		584,455	100.0	

Source: *Patients in Mental Institutions,* 1950 and 1951.[4] Tables C and D, pp. 20-21.

sions to all prolonged-care mental hospitals. (This total does not include temporary-care or intensive-treatment hospitals, nor does it take into account out-patient services.)

The second implication involves the ratio of admissions to resident patients as an index of rates of turnover. Remembering that the number of resident patients closely approximates the number of beds in each type of hospital, it is revealing to compare these ratios during 1951 for each type of hospital. For state, city, and county hospitals the ratio of admissions to resident patients was .28, for veterans' hospitals the ratio was .86, and for private hospitals it was 4.46. It is clear that the first group of institutions admitted far fewer patients in relation to their estimated bed capacity than veterans' and private hospitals. It is especially pertinent to compare veterans' hospitals with public (state, county, and city) mental hospitals, since those two groups of institutions showed surprising similarities in the median ages and diagnostic composition of their male resident psychiatric patients in 1951.[4, pp.159-179] If the public mental hospitals had been able to admit and discharge patients in 1951 at the same rate as the veterans' hospitals in relation to numbers of resident patients, they would have taken in 447,000 patients instead of the 146,476 actually admitted during the year.

Conclusions

In the light of the foregoing results, one may now specify more clearly what it is that rates of admission to public prolonged-care mental hospitals measure. Essentially these rates are nothing more than measures of incoming traffic in a selected group of institutions, which account for a little over half the patients admitted to prolonged-care mental hospitals of all types. The most likely reason why rates of admission for this particular group of institutions have been so extensively investigated is that their admission statistics are routinely published in official reports, where they are conveniently available for further study. There has been a tendency to leap to unwarranted conclusions in interpreting these statistics, with premature generalizations about the incidence of mental disorders in society as a whole. But it appears that differences between states in traffic through mental hospitals show only a tenuous, indirect relationship to differences in the actual incidence of mental disorders. These measures of traffic, while use-

ful for certain purposes, certainly do not reflect many social influences in the manner which some writers have suggested.

However, it is possible to make a number of other meaningful statements about these admission rates. For one thing, rates for individual states tend to remain surprisingly stable from year to year, despite the fact that rates of admission show enormous variations from state to state. Apparently these variations reflect differing administrative policies affecting admissions and discharges, rather than any sociological characteristics of the states themselves, as is often assumed. Differences between states in admission figures can be almost completely explained by differences in available bed space and in the amount of outgoing traffic measured by deaths and discharges. Admission rates may be raised by the introduction of newer, more effective treatment methods which, by increasing the number of discharges, make room for new admissions. As for social factors, the most important single variable seems to be the financial resources of the individual states.

Many discussions in this area seem motivated by a desire to make broad inferences about the social implications of figures on mental hospital admissions. For example, some authorities have held that the rising hospitalization rates of the last few decades reflect increased life stresses resulting from the rise of an urbanized, industrialized way of life. But this view has been challenged. In a recent investigation, Goldhamer and Marshall[10] reported that rates of admission to mental hospitals, at least for the younger age groups, have shown no appreciable change over the last several decades, and concluded that there had been no increase in the epidemiology of mental illness during the transition from the older rural, agrarian way of life to the modern industrialized social order. In contrast, Malzberg[11] has presented certain hospital admission data as evidence for a diametrically opposite conclusion.

Such contradictory conclusions can hardly be reconciled except by a careful evaluation of the nature of the original data. The present findings raise doubts about any assumption that traffic into selected hospitals constitutes a satisfactory or valid index of the occurrence of emotional disorders in the general population.

Why is it that rates of admission to mental hospitals in each state remain so stable from year to year, even when very similar adjoining states sometimes show great differences from their

neighbors in admission rates? And why do rates of admission to mental hospitals fail to show wide cyclical variations? Many other social indices of a psychologically relevant nature, such as suicide, crime, unemployment, income, and migration, fluctuate widely from year to year, far more than rates of admission to mental hospitals. Perhaps the nature of emotional disorders is such that their incidence does not fluctuate in cycles or in epidemics, like contagious diseases. However, when changes in admission rates do occur, the changes may often be attributed not to any increase in the incidence of mental disorders but to entirely different factors, such as better treatment methods which raise the discharge rate, the construction of new buildings, the passage of new legislation, and other events unrelated to any known causes of mental illness.

Another point deserving emphasis is the margin for error inherent in estimates of the nature and extent of mental illness that are based exclusively on state hospital data. It has been shown that state, city and county hospitals account for only a fraction of all patients, and that their rates of patient turnover are decidedly less rapid than in comparable institutions. If the former group of hospitals were able to admit, treat, and discharge psychiatric patients at the same rate as veterans' hospitals, the number of patients they could admit annually would triple without the addition of a single new bed. Now the extent to which admissions would actually rise if the efficiency of state, city, and county mental hospital systems were increased to the point where their turnover rates were comparable with veterans' or private hospitals is a hypothetical question. It has been demonstrated that the introduction of tranquilizing drugs was followed by an increase in discharges and a corresponding increase in admissions. Perhaps the same thing would occur on a larger scale if other new treatment methods, larger staffs, and more adequate treatment facilities were made available. Since the average length of stay in state mental hospitals is several years, it is obvious that a reduction of only one year in this average could have very appreciable effects.

Unquestionably, admissions to mental hospitals in the United States have increased substantially in recent years.[1] But a number of variables positively correlated with admission rates have also shown progressive changes in recent decades in directions making for higher hospitalization rates. Per capita incomes have

increased, providing more funds for the construction and operation of hospital facilities. The number of mental hospital beds per capita has risen, new and more effective treatment methods have been developed, and the average hospital stay has been shortened. Medical advances have increased the average life expectancy and, with it, the proportion of individuals surviving into the higher age brackets, where the incidence of mental disorders, like other infirmities associated with aging, reaches a maximum. All of these changes would tend to raise rates of admission to mental hospitals even though the "true" incidence of mental disorders in each age group of the population had remained constant.

But there is a more basic difficulty. As Scott[2] pointed out, the definitions of those much-used terms "mental illness" and "mental health" are still vague. Exposure to hospital treatment, although the most frequently used operational index of mental illness, is only one of several possible definitions. When the label "mental illness" is indiscriminately used to designate disparate kinds of behavior, whether the behavior be psychotic, neurotic, criminal, delinquent, or simply inappropriate by the standards of certain segments of society, there is room for confusion and uncertainty. The concept of a "mental illness" is an analogy drawn from medicine, not a behavioral concept. Systematic comparison of a "mental illness" with a medically recognized physical illness shows many fundamental differences between the two kinds of phenomena.

Colorful medical terms often have a way of creeping into popular speech and journalistic phrase-making. And so it is that we read in the newspapers about business men who "diagnose" and "treat" the financial "illnesses" of "sick" corporations, restoring them to a profitable state of economic "health." We read of city planners who "perform radical surgery" by demolishing slums, and road builders who "cure" the "arteriosclerosis" of overcrowded roads by opening new superhighways. No one pretends that these activities involve the practice of medicine. But similar misleading analogies are used to describe a heterogeneous, ill-assorted variety of organically and functionally induced personality changes, behavioral anomalies, and emotional disturbances, all of which are lumped together under the label of "mental illnesses." Unless the essential properties of a "mental illness" can be spelled out far more concisely than anyone has done so far, definitive

efforts to measure frequency of occurrence by hospital admission statistics, community surveys, or other case-finding techniques are doomed to failure.

Summary

A series of analytical studies of the correlates of rates of admission to public prolonged-care mental hospitals was conducted, using published statistical data broken down by states. Questions investigated included (1) the consistency of mental hospital admission rates from year to year, (2) the range of differences between states, (3) the relationship of admission rates to other indices of patient movement, (4) the influence of social variables on admission rates, (5) the effects of the tranquilizing drugs, and (6) a comparison of admission rates and patient turnover in various kinds of mental hospitals.

Over-all admission rates to public prolonged-care hospitals tended to be constant from year to year, with rates in individual states showing little variation. The changes that did occur seemed slow and gradual in nature.

A wide range of differences between states in rates of admission was noted, rates for the highest states being several times those of the lowest. Other indices of patient movement showed even greater differences between states. Rates of admission showed extremely high correlations with rates of discharge, deaths in hospitals, and resident patients per 100,000 population. It was concluded that differences between states in admission rates are almost completely determined by (1) the number of hospital beds in public mental institutions and (2) the rate at which deaths and discharges make bed space available for new admissions. Differences in patient movement apparently reflect differences between states in a number of complex legal, administrative, and institutional factors, which tend to be relatively stable in their effects from year to year.

Three social variables often believed to influence mental hospital admission rates, urbanization, income, and the size of the aged population, were correlated with average 1950-1955 admission rates. Urbanization and per capita income were positively correlated with admission rates, but when differences between states in income were held constant by means of partial correlation, the net relation between urbanization and admission rates dropped to virtually zero. It was suggested that differences between states in

hospital admissions were more a reflection of differing financial resources than of urbanization. Admission rates were not significantly correlated with the percentages of population aged 65 and over in individual states, even though age-specific rates for the nation as a whole are highest in the oldest age groups. In general, these three social variables seem to have a less direct influence on admission rates than differences in hospital administrative practices.

Examination of the effects of tranquilizing drugs showed that following their introduction there was a substantial rise in discharge rates, but that there was an equivalent increase in admissions. It was thus demonstrated how new treatment methods could indirectly cause admission rates to go up, even though the incidence of mental illness in the general population remained unchanged.

A comparison of admission and patient turnover rates in public (state, county, and city) prolonged-care mental hospitals with corresponding figures for veterans' and private hospitals revealed that admission and turnover rates for the latter two types of insitutions were much higher. If rates of patient turnover in public mental hospitals had been as high as those for veterans' hospitals, the number of admissions in a recent year would have tripled.

The significance of the rise in admissions to mental hospitals in the United States over the past few decades was critically discussed in the light of these findings. On the basis of available evidence, it does not appear that this rise can be attributed to any real increase in the incidence of mental illness.

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REFERENCES

1. Felix, R. H., and Kramer, Morton: Extent of the problem of mental disorders. Ann. Am. Acad. Pol. and Soc. Sci., 286: 5-14, March 1953.
2. Scott, W. A.: Research definitions of mental health and mental illness. Psychol. Bull., 55: 1, 29-45, January 1958.
3. United States Department of Health, Education and Welfare: Mental Health Statistics, Current Reports. Series IMH-B53, No. 1, December 1952, and No. 2, April 1953. Series IMH-B54, No. 1, May 1954, and No. 2, December 1954. Series MHB-H-1, January 1956. Series MHB-H-2, December 1956. United States Government Printing Office. Washington.
4. ——: Patients in Mental Institutions, 1950 and 1951. United States Government Printing Office. Washington. 1954.

5. United States Department of Commerce, Bureau of the Census: Current Population Reports, Population Estimates. Series P-25, Nos. 62, 87, 97, 108, and 129. United States Government Printing Office. Washington.
6. Hansen, Harry (editor): The World Almanac and Book of Facts for 1956. New York World-Telegram and Sun. New York. 1956.
7. ——: The World Almanac and Book of Facts for 1957. New York World-Telegram and Sun. New York. 1957.
8. United States Department of Health, Education, and Welfare: Health and Demography. United States Government Printing Office. Washington. 1956.
9. Leacock, Eleanor: Three social variables and the occurrence of mental disorder. In: Explorations in Social Psychiatry. A. H. Leighton, J. A. Clausen, and R. N. Wilson, editors. Basic Books. New York. 1957.
10. Goldhamer, Herbert, and Marshall, Andrew: Psychosis and Civilization: Two Studies in the Frequency of Mental Disease. Free Press. Glencoe, Ill. 1953.
11. Malzberg, Benjamin: The increase of mental disease. PSYCHIAT. QUART., 17:3, 488-507, July 1943.

EDITORIAL COMMENT

HOW WIDE IS OPEN?—HOW HIGH THE MOON!

A young man was looking for a furnished room in Greenwich Village—back in the roaring twenties. His prospective landlady called attention to the comfortable bed, the large chest of drawers, the easy chair, the plentiful light and air, the view of Washington Square; then she mentioned the crowning attraction. "And there's an 'open door' on the third floor, just upstairs." It is not recorded whether the young man ever called on the lady upstairs, but he was permanently impressed by the fact that it is not really the position of the door, but what is inside it, that counts.

In the case of the open door hospital, it is also what is actually inside the open door that counts. With no malice toward those who so loudly applaud the open door, and with full approval of their objectives, emphasis must still be placed on the fact that the indiscriminate use of the open door by itself—like the indiscriminate use of any "therapeutic maneuver"—is not a panacea for mental disorder; the open door can be used wisely or abused, like any other manipulation. To quote Hacken and Hunt,* who may fairly be described as open door zealots, "The writers do not for a moment believe that the open door system alters the primary psychotic process. It is their conviction that the open door is not, and must not be thought of as, a substitute for good treatment of the disease."

The current American open hospital is a recent import from Great Britain, although there were practices closely resembling it in American institutions well over a century ago,** and the model

*Hacken, Emanuel, and Hunt, Robert C.: Open ward management of acute patients in a multi-story building. PSYCHIAT. QUART. SUPPL., 23:2, 189-196, 1959.

**In the Second Annual Report of the New York State Lunatic Asylum at Utica, dated November 30, 1844, Amariah Brigham writes, "After a few days, when we have become acquainted with the patient, we usually allow him to join in the various exercises and amusements of the Asylum. He goes out to walk or ride... Many who are at home rude and violent, and not disposed to submit to the guidance or control of others here immediately conduct with propriety and conform to our regulations. ... But it must be evident to all that some patients (... rarely amounting to ten in an hundred...) cannot be thus treated—that some are too violently deranged to comply voluntarily with any regulations..."

Almost one hundred years later, members of this QUARTERLY'S editorial board, serving at Utica State Hospital under Richard H. Hutchings, signed "late city permits" each night for a dozen patients or so on each service and recognized "honor cards" for about 25 per cent of the hospital population.

for it may, in fact, be found in Belgium where for centuries there has been, not an open door hospital, but an "open door hospital-town" at Gheel.* The beginnings of Gheel are lost in what—according to one's personal convictions—can be called either legend or medieval history. The story goes that the "open door town" of Gheel dates from late in the sixth century, when Saint Dymphne was murdered there and many of the mentally ill recovered on pilgrimages to her shrine. At least, for centuries when the mentally afflicted were being imprisoned, beaten, put to death, and otherwise mistreated all over Europe of the Middle Ages, open door homes and what we should now call the "milieu treatment" of a friendly family atmosphere were accorded them at Gheel. Many families received and "treated" patients for generation after generation. And there were remissions or cures on visits to Saint Dymphne's shrine. In recent times, the milieu treatment and religious treatment have been supported by enlightened medical measures and medical supervision.

If an open door hospital-town, why not an open door hospital? There is no available record as to whether this question passed through the minds of the British psychiatrists, Bell at Melrose in Scotland and MacMillan at Mapperly, Nottingham, when they threw open their doors, to create open door hospitals in Great Britain.** The underlying theory, at any rate, was pretty much the same. Briefly, to deprive a patient physically of his freedom is frequently to add, to his existing mental symptoms, new ones created by his feeling of being imprisoned. Set him free physically, and he will lose the superimposed symptoms and be much more amenable both to care and treatment. This, of course, has long been known.†

*Encyclopaedia Britannica (14th edition): Article on Ghell. Vol. 10, p. 323. Encyclopaedia Britannica. Chicago. 1948.

Henry, George W.: Mental hospitals. In: A History of Medical Psychology. By Gregory Zilboorg and George W. Henry. Norton. New York. 1941.

Doll, Edgar A.: The lesson at Gheel. Chapter VII in: Family Care of Mental Patients. Horatio M. Pollock, editor. State Hospitals Press. Utica, N. Y. 1936.

**Beresford, Cecil: Psychiatry in Great Britain today. PSYCHIAT. QUART., 33:2, 221-251 and 437-465, April and July 1959.

†Credit Dr. Mathew Ross for collecting for the American Psychiatric Association Mail Pouch an item printed in a Canadian journal under the heading of "Nothing Is New Dep't." It quotes the ninth edition of the *Encyclopaedia Britannica*, published in 1881, as follows: "Experience has shown that as restraint of all forms is abandoned, the management [of the mentally ill] becomes easier. Walled-in-airing courts, barred windows, and strong dark rooms have almost entirely disappeared, and in some Scotch asylums it is found practicable to discontinue the use of lock and key."

Besides its practical applications at Gheel for well over a thousand years, the general principle involved has been applied in mental hospital practice since the days of Tuke and Pinel. "Moral" treatment—as developed in France and England, and in this country by Amariah Brigham and his successors—was the application of kindness and consideration to the therapeutic relationship of the doctor to mental patients. Freedom from physical restraint is one aspect of this kindness and consideration. The open door is one modern aspect of freedom from physical restraint. The advance of the open hospital in Great Britain has been duly noted in this journal,* as well as its adoption by institutions in the United States.** One hospital of the New York State system of mental institutions is generally regarded as now "completely open," or almost so (and except at night). As with some other doctrines the "all or nothing principle" is stressed. Despite some practical difficulties, no ward must be locked if one is to achieve adequate therapeutic effect and proper rapport with the patients —so it is said! Otherwise the beneficial influence is vitiated. Most of the other hospitals have greatly increased the numbers of their open wards, until—in the typical New York State institution—a comparatively few remain "closed." The "opening" of the "completely open" hospital, St. Lawrence State Hospital, is described by its director, Herman B. Snow, M.D., in this issue of THE QUARTERLY, and a British report which has some bearing on the subject also appears in this issue.† In the last three years, *The American Journal of Psychiatry* has had at least half a dozen articles about the open hospital; in the last five years, *Mental Hygiene* (which is intended for general rather than professional reading) has published three; since September 1959, *Mental Hygiene News*, the "newspaper" of the New York State Department of Mental Hygiene, has published eight.

The open hospital has, in fact, become a psychiatric fad, which is not anything against it. Both good and bad treatments have been such fads. Weir Mitchell's rest cure was one such fad, and

*Beresford, Cecil: Op. cit.

Hordern, Anthony: British psychiatry today. PSYCHIAT. QUART., 32:2, 342-375, April 1958.

**Hacken, E., and Hunt, R. C.: Op. cit.

†Snow, Herman B.: The open door hospital. PSYCHIAT. QUART., 35:2, 211-230, April 1961.

Annesley, P. T.: A rehabilitation unit on group therapy lines for long-stay patients. PSYCHIAT. QUART., 35:2, 231-257, April 1961.

it turned out to have been poor treatment. All treatments of value, however, have been overdone as fads. So, this QUARTERLY thinks, however good the open door is, it can be overdone to the point of harm if it is used indiscriminately as a fad. And the hurrah about it can be vastly overdone.

In the United States, the opening of hospitals has been made possible by the use of the "new drugs." One may still dispute what these drugs are or what they do, as evidenced by the various names which have been proposed for them—"tranquilizers," "ataractics," "phrenopraxics." One may agree with Hoch and others that they do not (properly used) "represent a chemical restraint. ... patients are not restrained by the drug. As a result of drug therapy these patients are less tense, less excited, less upset and therefore they function better and behave more normally than before."* But one may also observe that, in this same discussion, Hoch states that, with the new drugs, "we are able to sedate the patient ... without inducing sleep." Many of the first wards to be opened were opened by virtue of oversedating the patients "without inducing sleep." We, or most of us, do better now.

There is competent, though perhaps not unbiased, testimony to the effect that some of America's first "open" hospitals were opened by a general application of this oversedating method. And those who are unable to agree that the new drugs "sedate ... without inducing sleep" can call the process "overtranquilizing" if they prefer. But this is by no means the only method of curtailing the activities of patients, even when wards are open. One can, for instance, in a tall building, withhold the honor cards without which patients cannot enter the elevator. Or one can seat a husky attendant beside an "open door" to ask "Where inell do you think you're goin'?" whenever a troublesome patient appears. "Store cards" can be withheld from patients who abuse open door privileges. Clothes can be taken away. There are indeed numerous other ways of seeing that open doors are not completely free rights of way.

Some other qualifications are to be noted. One reason for certifying a patient to a mental institution is that he is not "socially acceptable." If such a patient is permitted to wander outside the hospital at will, he will encounter many situations in which he

*Hoch, Paul: New aspects of treatment for mental illness. Ment. Hyg., 41: 3, 415-419, July 1957.

is not "socially acceptable." He will also find himself in situations where he is "dangerous to himself or others." Beresford,* in whose hospital, the famous York Retreat, most of the doors are open, has something to say on both subjects. He points out that in a small private institution like the York Retreat, or the New York Hospital—Westchester Division, special nursing care can be provided during periods of observation and investigation for patients who are "in violent mania, or very actively suicidal."

"In the majority of state hospitals, however," says Beresford, "this is not possible. With the risk of a suicidal woman running away and killing herself or of a violent patient committing some dangerously aggressive act, the practice in most of these open door hospitals seems to be to admit; treat at once with electric shock therapy, perhaps within an hour of admission; and keep treatment up until the patient quiets down. This, done before full investigation, is, as all admit, very bad medicine and a big disadvantage." Beresford then cites another drawback of the 100 per cent open hospital, the annoyance to friends, relatives, neighboring storekeepers and the police that an unsupervised and socially unacceptable patient can cause. All of us know of cases, pre-dating the open hospital, where permission to leave the grounds had to be revoked because patients persisted in talking or "flirting" hour after hour with storekeepers, waitresses, and salesgirls. Beresford reports a patient from a newly-opened ward who applied to a nearby bank for a loan of £150,000,000 to open a maternity nursing home for several hundred "breeding girls" whom he expected to import to England from Ireland; he apparently was to be the father.

Beresford's banker was an understanding soul; but such performances, if constantly repeated, cannot add to the happiness of a community. And the hospital has an obligation to the community as well as to the patient. It may be against this background that our own most publicized open hospitals should be viewed. Of those so publicized in the New York State system, the "fully open" one is around a couple of miles from a little city of about 16,000 people; an "almost fully open" one is on the outskirts of a place of some 38,000. No New York state hospital in a big city or in a congested district of a small one has thrown all or almost all of its doors open. The one hospital which

*Beresford, Cecil: Op. cit.

reports that its doors are completely open is more strategically located.

Furthermore, there may be therapeutic reasons, other than danger to themselves or other people, for not placing all new patients immediately on open wards. Psychiatrists should not require reminders that all mental illnesses are not alike. There is no more warrant for the belief that the open door will benefit all patients, from the agoraphobic psychoneurotic to the restless manic, than there was for the belief that psychosurgery would. Everybody is aware of the patient for whom the ward with locked doors represents security and refuge—perhaps the uterus. Beresford cites a case of this sort.* And such a situation is dramatized now and then by some happening to an unhospitalized psychotic, the recluse who is found to have lived for years behind tightly closed windows and doors, or the extreme case of the person who sleeps in a closed contraption, securely locked on the inside. In one reported instance of a few years back in New York City, the man who locked himself in a box of strap iron every night was found to have gone for years in extreme fear of contact with women. One may suppose that such a person would be less distressed and disturbed in a closed ward than in an open one.

Snow, zealot for the open door as he is, points to some of the practical problems and difficulties.** For one thing, he discusses the criminal order case. His solution, as he himself notes, the examination of persons charged with crime elsewhere than in the open hospital, is less than perfect. For one thing, he reports, although judges were co-operative, some did not know of the hospital's request that examinations be made elsewhere, and sent criminal order cases along for admission. He reports having to ask for a deputy sheriff to guard one such person who was charged with murder. But several questions remain unanswered. What provision can be made in a "100 per cent open hospital" for a person (note—he is often not a habitual criminal) facing criminal charges who needs protracted professional observation, not mere examination? Long psychiatric experience demonstrates that such a person should have a full psychiatric examination over a number of hours in a proper setting. The examiners often require psychological, laboratory, medical and social work data to come to

*Beresford, Cecil: Op. cit.

**Snow, Herman B.: Op. cit.

an honest opinion. It is also true that a good examination also requires qualified nursing observation over a number of weeks. In an out-patient section, a prison, a warden's office—you can't get this. What provision can be made for the patient whom there is reason to consider potentially homicidal, but who is certified or even admitted voluntarily by ordinary civil procedure, not court order?

Beresford brings up another problem, which Hordern also cites as one that has plagued the British open hospital.* It is the problem of the psychopaths, who appear to be in larger proportion in the British than in the American state hospital populations, for they can be committed by magistrates to British institutions, and the superintendents have "no right of refusal" while many American state hospitals can refuse them if they are not psychotic "within the meaning of the law." Beresford says:

"... All varieties of psychopaths, persistent razor blade swallowers, phony suicide cases, quarrelsome, antisocial and aggressive types, and of course the whole gamut of sex perverts and drug addicts are sent in on certificate from time to time. Without exception, they walk out of an open door hospital as soon as their need for a bed, lodging or exhibitionism is satisfied. They will frequently commit some crime or other, and the usual hue and cry arises in the press, 'Mental patient bludgeons and robs old woman' —'Walked Out of Open Door Hospital'—'Why should dangerous lunatics be allowed their freedom in this way?'—'Neglect on the part of psychiatrists'—and so on. ... There is no doubt that, in some localities unhappy experiences of this kind have caused the hospital authorities to keep the wards locked because of the strength of local prejudice created by some incident of this kind. Almost without exception, a psychopath not a psychotic is the cause of it."

The conventional closed door hospital in the United States has also had plenty of experience with this sort of thing. There are enough psychopaths in our institutions, with or without psychosis, to build up a sizable peripatetic population. A suggested British solution is to set up separate institutions for the psychopaths—which has been suggested in the United States also for other reasons. But pending such a solution, for which there is little

*Beresford, Cecil: Op. cit.
Hordern, Anthony: Op. cit.

present prospect, where are we to find the personnel to watch wandering psychopaths in a completely open hospital—particularly in urban surroundings? The shortage of personnel has been discussed largely in terms of the professional services.* But nonprofessional mental hospital jobs are not attractive to many persons and quotas of personnel are inadequate even for the closed ward institution.

A new problem recalling Snow's difficulties with criminal order patients has been handed to the civil state hospitals by the 1961 New York State Legislature. Patients who have completed prison sentences at Dannemora, in addition to those already being received from Matteawan (both state hospitals for the criminal insane), may now, if suitable for treatment, be transferred to the civil state hospitals as ordinary civil patients. These people were "criminals" when committed, and although some of them have been confined for long periods, one may doubt that their proclivities have been altered. A "100 per cent open hospital" would not seem the best possible environment for them.

An interesting comment on the dangerous patient appeared in *The Caduceus,* the bulletin of the Dutchess County Medical Society a few years ago, when the doors of Hudson River (N.Y.) State Hospital (Hunt's institution) were being opened.** *The Caduceus* remarks that "... a patient found even remotely dangerous after close, individual study would still be held in the necessarily confined group." Few psychiatrists are to be encountered who would consider that no patients were "even remotely dangerous."

How wide is open? This question will be answered readily by the authority who knows *How High the Moon;* but, while we are waiting for an answer, there is a great deal of double talk about it. When the Department of Mental Hygiene announced the open hospital as the official policy of the New York State system, what "open hospital" meant was a matter for interpretation. It could conceivably mean one thing in Ogdensburg, where St. Lawrence State Hospital is located, and another in Brooklyn—and it apparently has. In no place, does it mean a hospital where all patients

*Editorial: Knell for a nursing service. PSYCHIAT. QUART., 34:1, 150-152, January 1960.

Albee, George W.: The manpower crisis in mental health. Am. J. Pub. Health, 50:12, 1895-1900, December 1960.

**Editorial: The Open Door. A Reawakening of Hope in Patients. Reprinted from The Caduceus in Ment. Hyg. News, XXIX, 1, September 1958.

are completely free to go and come at any time. Snow's definition is a hospital where every ward is open at least eight hours a day. It will be seen that even the 100 per cent open hospital is not open at night. It is closed, in fact, at least half the time. And with this qualification of "100 per cent," St. Lawrence is said to be one of only two 100 per cent open hospitals in the whole United States; the other is at Embreeville, Pa., which also appears to be in a rural area.

Hunt's "open hospital," Hudson River State Hospital at Poughkeepsie, has by what appears to be his own estimate, about 92 per cent of its patients in open wards.* As he remarks in the same interview where this figure is given, there is no precise definition of an open hospital and there are many degrees of open wards. In fact, there are so many qualifications, inconsistencies and apparent contradictions that when a director boasts of an "open hospital" the term covers a wide scale and can mean—like a "hot day"—just about whatever he chooses to make it mean. In Hunt's "open hospital" some patients may not leave closed wards, some may not leave open wards, some may not leave the grounds, some may not go downtown, and some (alcoholics who have abused their privileges by getting into brawls on downtown visits) may be put into pajamas and thus confined indoors—by order of a committee of patients themselves. This last, patient-imposed punishment, be it noted, is one of the indignities cited in the Hunt interviews as part of the admission procedure of the old closed ward hospital—to deprive the patient "of his freedom, his clothing and his intimate personal belongings." It is also to be noted, that even in "the 100 per cent open hospital," the patient may go behind locked doors at once if he happens to be admitted at night when the admission ward is not an open ward.

Snow's and Hunt's open hospitals are, as has been remarked, the most publicized in the New York State system. It may fairly be contended that the other hospitals also are meeting the goal set by the department of having their doors open, but the width of the openings varies with circumstances. There are institutions where—unlike the situation at Snow's rural hospital—disoriented geriatric patients cannot be permitted to wander off unfenced grounds where they may be killed by heavy traffic. There are others where hypomanic young women should be guarded from

*Hunt, Robert C.: Series of interviews in: Medical Tribune, January 23, January 30 and February 6, 1961.

pregnancies resented by their husbands, and susceptible youngsters should be shielded from homosexual wolves. There are others where lack of personnel or old-fashioned arrangement of buildings makes it impracticable as yet to open all the wards. There are some where directors do not feel they should use electric shock or tranquilizers indiscriminately before complete study and diagnosis. Again, some directors also feel that they cannot guard an actively suicidal, or an actively assaultive, or a grossly confused admission without at least temporary use of locked doors.

Yet the orientation of these hospitals may be seen as "open." The objective of all is, of course, to get the patient out of the hospital as soon as possible, and, pending this, to get as many as possible into open wards where they will have as much freedom as possible. In these hospitals, 40 per cent, or 60 per cent, of the hospital population already have the benefit of open doors. This is in sharp contrast to the pre-tranquilizer days when perhaps 10 or 25 per cent of the best-behaved patients had cards entitling them to freedom of the grounds and a lesser number were allowed off the grounds on special permit. That situation has been reversed; the open door is now the rule, not the exception, and most administrators are actively seeking means to extend its benefits.

The most fundamental objection to hectic hurrahing about the open door is still the fact that opening doors is too often mistaken by the psychiatric profession, the public, and perhaps the patients as well, for adequate treatment in itself.*

*For presentation of the open hospital theme to the public, see "Hospitals Without Doors," news item in *Time*, June 23, 1961. *Time*, reporting to its readers on the North American lecture tour of Dr. Joshua Bierer, British psychiatrist who heads the Marlborough Day Hospital in London, says his solution for the mental hospital problem is to "tear down most of the hospitals." Dr. Bierer, as *Time* notes, has been preaching the open door and the tear-them-down doctrine to professional audiences.

Time devotes an illustrated column and a half to presenting the open door idea to the general public. Most of the space is allotted to Dr. Bierer, but with brief notes on a "therapeutic community" in Nigeria, a "modest mental health center" in India (both apparently "open"), and a day hospital in Boston. The only mentions of treatment are a remark (*in a paragraph devoted to showing the allegedly vast amounts of money that unlocking hospitals doors will save*) that "Day, night and weekend hospitals . . . [are] intensively using group psychotherapy . . ."; a note that "psychiatry" in Nigeria "incorporates many aspects of the tribal cults, including religious sacrifices"; and a somewhat ambiguous statement relating to the Indian health center which may indicate that patients "are treated." There is no word on treatment in Boston.

The *Time* reader can hardly avoid getting the impression that treatment is of no consequence whatever, that the "open door" is the answer to everything.

But the open door is no substitute for adequate over-all treatment—while, in fact, it demands a complete, well-integrated, full-time therapeutic and activity program. The open door is a very fine thing. So is the American business man's favorite dessert, apple pie topped with vanilla ice cream. But apple pie topped with vanilla ice cream is no substitute for an adequately balanced meal; even the American business man can't live on it.

The value of the open door still lies in what is inside it. And those who have overpublicized it still owe the profession and the public an answer to the question: How wide is open?

BOOK REVIEWS

The Psychology of Character Development. By Robert F. Peck with Robert J. Havighurst, and Ruth Cooper, Jesse Lilienthal and Douglas More. 267 pages. Cloth. Wiley. New York. 1960. Price $6.50.

The present study is another psychological investigation conducted in the already much-studied and reported "Prairie City." Its rather ambitious purpose was to assess the "moral" condition of children born in 1933 and living in Prairie City in 1949 and then to determine what factors were correlated with the character assessment. (In the study correlation is often confused with the notion of causation.) The psychologic apparatus employed (both in terms of test battery and method) is much too complex to be summarized briefly. It was, in fact, of a staggering degree of complexity. Under such circumstances, it is not surprising to discover that of the 120 available children only 34 were intensively studied.

No one, to this reviewer's knowledge, has ever succeeded in developing a wholly satisfactory technique for character assessment. Peck (for it is Peck who is basically the author of this book) sets out by developing a "motivational theory of character." The intent to do good to other people, he assumes, makes for a good moral character and the intent to do evil makes for a bad one. One agrees with him and is interested to know how he comes at intent. As might be expected, he relies to a large extent upon what the teachers and contemporaries of the children studied think. He also has his own battery of tests and interviews, but since these agree pretty well with what others think, and since the estimation in which the children were held by others agrees closely with their scholastic rating, one begins to grow uneasy. What if Spinoza's claims to moral stature had been submitted to the Jewish congregation in Amsterdam? What would a rating of Kierkegaard by Myster have looked like? What, for that matter, would we anticipate if the Sanhedrin had been asked to file a credit rating on Christ's moral character?

In order to organize his own test apparatus, Peck develops five basic character types: amoral, expedient, conforming, irrational-conscientious and rational-altruistic, which represent (for him) an ascending scale of moral values. Since the employment of terms such as amoral and rational-altruistic sound suspiciously like begging the question one wonders exactly what Peck means by amorality. It is with some surprise that we find the amoral character type equated with "what is often called clinically the 'psychopathic personality.'" No one doubts, of course, the amorality of psychopathic personalities, but certainly not all persons who plot evil for their fellows are psychopaths, and who would say that most, if not all, psychopathic personalities really intend to do evil to others. Peck attempts (though

just why is not obvious) to equate his five character gradations with developmental periods ranging from infancy to adulthood and subscribes to features of what he calls neo-Freudian theory. To synthesize his five, basic character constructs, he develops a kind of factor analysis in which six personality "characteristics" are found to be relevant. These are moral stability, ego strength, super-ego strength, spontaneity, friendliness and a hostility-guilt complex.

To arrive at these factors a formidable array of interviews, ratings, projective techniques, sociometric instruments, mental tests and achievement records and questionnaires was employed. On the basis of his material, Peck reaches some conclusions which—such as that character is determined within the family—are not especially startling, and goes on to "Some Speculations about Character in Modern Society" and "Toward a Scientific Basis for Ethics." These discussions are full of words such as "good," "erratic," "unscrupulous," "stable," "sincere," "ought," and "non-rational." It is not exactly clear what relation the 34 children in this study bear to conclusions relating to "cyclical wars" (p. 202); but, by the end of the book, Peck has managed to gain a great deal of altitude.

Somatosensory Changes After Penetrating Brain Wounds in Man. By JOSEPHINE SEMMES, SIDNEY WEINSTEIN, LILA GHENT and HANS-LUKAS TEUBER. 91 pages. Hard cover. Harvard University Press. Cambridge, Mass. 1960. Price $4.00.

This is a comparative study on a statistical basis of the losses in sensory function following penetrating wounds of the brain in previously healthy adults. The authors have obtained quantitative data in an attempt to assess the effects of injury to different portions of the brain. They present evidence suggesting that the sensation of the left hand is more diffusely represented in the hemisphere than that of the right hand, that sensation of the left hand is frequently affected by lesions of the ipsilateral sensory motor region, and that the nature of sensory impairment of the left hand is not the same as that of the right hand.

The charts, appendix and references are well prepared. As a specialized book for the advanced student or practitioner in neurology, it is excellent.

Child and Juvenile Delinquency. BEN KARPMAN, M.D., editor. 364 pages plus index. Cloth. Psychodynamics Monograph Series. Washington, D.C. 1959. Price $10.00.

The contributions in this set of symposia were originally presented before the American Orthopsychiatric Association and were published in part in the *Journal of Orthopsychiatry*. The five round tables are presented here in full and make for some stimulating reading. Although one may be annoyed with the numerous irrelevant and extremely unimaginative illustrations, the book as a whole is recommended to all professionals who are in any way interested in the understanding of the youthful offender.

Cardiovascular Effects of Nicotine and Smoking. CARL J. WIGGERS, conference chairman, with 68 authors. 334 pages. Paper. New York Academy of Sciences. New York. 1960. Price $4.00.

The smoking habit occupies a psychiatrically interesting place in our culture. Added to all the data which suggest that the smoker is paying an exorbitant amount in order to subject himself to an increased risk of pulmonary, gastro-intestinal, ophthalmologic and otorhinologic disturbances, there is, in the present volume, evidence that appreciable cardiovascular danger may be involved. The physicians who continue to smoke must, therefore, justify their position upon the grounds (a) that the evidence of harm is inconclusive, (b) that there are benefits which outweigh the damages, (c) that they just don't give a damn or (d) that they can't break themselves of a potentially damaging habit. While the last two reasons may be accepted as adequate by the psychiatrist, the laity is not likely to think very highly of the physician who cannot offer better evidence of self-control. The second argument is usually employed by aged practitioners who take the position that maximum damage has already been done in their cases and that nothing but an upset in homeostasis (a loss of tranquilizing effect) would be achieved by quitting. Generally a rejection of the adverse opinion is based upon the first hypothesis. In this connection Wiggers' introduction to the present volume seems especially pertinent for the physician who is of the mistaken opinion that science is advanced by critically-proved experiments. Wiggers emphasizes what every experienced experimenter knows—that research can only indicate the greater or lesser probability of certain circumstances within the obtaining frame of reference.

This being the case, the reviewer thinks that the physician who demands further and greater degrees of proof that smoking may be damaging is just seeking an excuse to avoid looking the available facts in the face. To argue that what is staring right back at one are not facts invites the obvious rejoiner, "Where are we then?" "Indications, hints, possibly prejudices, nothing more," one might answer. To this the present volume offers some disturbing conclusions. Throughout the volume, runs the theme that the deleterious effects of nicotine upon nonsmokers is less, rather than greater, than upon smokers. In addition the evidence is clear that not only persons with hypertension and coronary accidents react less satisfactorily to the drug than do "normals" but so also do individuals whose parents have had a history of hypertension or coronary disease.

On the positive side, one can find little. Comroe, basing his comments on a 1942 paper by L. M. Johnston (Lancet 2:742) states, "Nicotine is not an analeptic (like metrazol), nor does it produce wakefulness and insomnia (like amphetamine). Nevertheless, it does have subtle effects on man's psyche. Although it is hard to identify the effect, it appears that

smoking produces pleasurable reactions or tranquility and that this is due, at least in part, to nicotine, and not entirely to the physical manipulations involved in smoking."

Whether such physiologic effects as may be elicitable by sham smoking would long resist extinction, seems not to have been investigated. Evidently such physiologic benefits as may be obtained from smoking can be classified under the heading of tranquilization, and this effect is either directly dependent upon nicotine or is conditioned upon it.

Hermetic Philosophy and Alchemy. By M. A. ATWOOD, with introduction by WALTER LESLIE WILMHURST. 597 pages, plus 64-page introduction. Cloth. Julian. New York. 1960. Price $15.00.

Walter Wilmhurst, in his introduction, states that this book has a strange history. It was written by a woman during the middle of the nineteenth century. Shortly after publication, it was withdrawn, and the author attempted to buy back the copies that had been sold.

For some reason, Mr. Wilmhurst thinks the book has value, and apparently the publishers agreed. The reviewer has no detailed knowledge of the history of alchemy and cannot comment on the accuracy of the statements of historical nature.

The author apparently divides alchemy into the physical and spiritual, and in the physical describes a pure substance which can change large quantities of impure substance into pure substance, the latter apparently being gold or gold-like.

The writing is vague, circumstantial, garrulous, involved and difficult to follow, with numerous references to ancient and medieval philosophers and writers. If one did not wish to be charitable, one could consider the writing schizophrenic. There may be some value of a historical nature in republishing such a book, but the purpose is lost to this reviewer. The best that can be said is that the publication itself is excellently done.

The Man Who Feels Left Behind. By GERALD W. JOHNSON. 170 pages. Cloth. Morrow. New York. 1961. Price $4.00.

Johnson, a newspaperman turned author, has 20 books to his credit; he became widely known for the publication of a courageous piece in *The Atlantic Monthly,* "To Live and Die in Dixie"—a southerner declaring that the South has not been right on the segregation issue. He continues his polemic, enlarging on the scope, including many other topics, especially the "American who feels that the scientific age has left him behind." He gives the impression that he does not care whether the reader agrees or disagrees. His best sentence starts: "Nevertheless, irrevocably committed to the illusion that I am sane..."

The Philosophy of Science. ARTHUR DANTO and SIDNEY MORGENBOSSER, editors. 477 pages. Paper. Meridian. New York. 1960. Price $1.65.

This book is subtitled "Readings Selected, Edited and Introduced by the Editors, With a Preface by Ernest Nagel." It is divided into three parts, Part 1 being headed "Science, Language and Experience." There are articles by Galileo, Bertrand Russell and Carl Hempel. This section deals with the relationship of facts, language and philosophy.

Part 2 deals with laws and theories. Once again, there are several original articles, including papers by Oppenheim, Mach, Scheffler, and interpretations by the editors.

Part 3 is called, "Space, Time and Causality," with articles by Newton, Berkley, Hertz, Mach and Poincaré.

This book covers the philosophy of the physical sciences well, with various interpretations and thought-provoking articles. A knowledge of mathematics and physics is not essential to its understanding, although some such knowledge makes the reading of some of the articles much easier.

Fundamentals of Psychology: The Psychology of Thinking. ERNEST HARMS, editor, and 11 authors. 158 pages. Paper. New York Academy of Sciences. New York. Price $3.50.

The purpose of the conference which gave rise to the present monograph is stated in the introduction by Dr. Harms to be an effort to arrive at agreement among the various schools of psychologic thought on problems of fundamental importance in psychology. What Harms is attempting to do is to develop a structured approach to first principles. This he envisions as the psychology of the future. For the present conference the fundamental psychologic process considered was thinking. The monograph is divided into four parts (1) theoretical aspects of the psychology of thinking, (2) developmental problems of the psychology of thinking, (3) measurement of thinking, and (4) creativity and thinking.

Progress in Psychotherapy. Volume IV. JULES H. MASSERMAN and J. L. MORENO, editors. 361 pages including index. Cloth. Grune & Stratton. New York. 1959. Price $8.75.

The 41 articles in this volume, gathered from practically everywhere in the world, are all pooled under the subtitle, "Social Psychotherapy." Contributions from practitioners and researchers in countries such as Czechoslovakia, Formosa, Israel, and Peru make this 1959 annual particularly interesting and valuable. Moreno's introduction, 'The Current Climate of Social Psychotherapy," is revealing and noteworthy, although unnecessarily long. The entire volume is a very welcome addition to the literature and will be appreciated by professionals in the fields of psychiatry, psychology and social work.

The World of Zen. An East-West Anthology. NANCY WILSON ROSS, editor. Introduction by Nancy Wilson Ross. xvi and 362 pages with index and numerous half-tone illustrations. Cloth. Random House. New York. 1960. Price $10.00.

Mysticism: Christian and Buddhist. By D. T. SUZUKI. Vol. XII, World Perspectives. RUTH NANDA ANSHEN, editor. 214 pages. Cloth. Harper. New York. 1957. Price $3.50.

Zen Buddhism and Psychoanalysis. By ERICH FROMM, D. T. SUZUKI and RICHARD DE MARTINO. 180 pages with index. Cloth. Harper. New York. 1960. Price $4.00.

The Supreme Doctrine. Psychological Studies in Zen Thought. By HUBERT BENOIT. 248 pages with index. Paper. Viking. New York. 1959. Price $1.25.

Zen: A Rational Critique. By ERNEST BECKER, Ph.D. 192 pages with index. Cloth. Norton. New York. 1961. Price $4.00.

The Spirit of Zen. A way of life, work and art in the Far East. By ALAN W. WATTS. 128 pages with glossary, bibliography and illustrations. Paper. Grove, Evergreen Edition. New York. 1960. Price $1.45.

Zen and Shinto. The Story of Japanese Philosophy. By CHIKAO FUJISAWA, Ph.D. 92 pages. Cloth. Philosophical Library. New York. 1959. Price $2.75.

The Zen Teaching of Huang Po. On the Transmission of Mind. JOHN BLOFELD (Chu'an), translator. 136 pages with index. Paper. Grove, Evergreen Edition. New York. 1959. Price $1.25.

The philosophy of Zen is exerting a tremendous and presently growing impact on the Western World. As psychiatrists are, on the whole, well aware, its influence has not been confined to religion or to thought in general, but has had sweeping and practical effects in the fields of psychology and psychotherapy. The volumes reviewed here are written or edited by seven Westerners interested in Zen principles and all but one sympathetic to them, and two Easterners including Dr. D. T. Suzuki, distinguished Japanese philosopher who has lived for many years in the United States.

Nancy Wilson Ross' *The World of Zen* is a book of a most unusual sort, an anthology which can serve as a sweeping introduction to its subject. Miss Ross, author among other works of a delightful and widely-read novel based on Buddhist teachings, *The Return of Lady Brace,* has been a serious student of Zen for what she herself calls "a number of years." Her anthology appears to have been compiled with great discrimination and brilliant discernment.

Among numerous other distinguished contributors, Miss Ross' authors include most of those whose works are reviewed separately here; she calls Dr.

Suzuki her "major contributor." Others, reviewed here, whose material she has drawn upon, include Watts, Fromm, Benoit and Blofeld. Ruth Fuller Sasaki, American-born woman, ordained Zen priest and head of a Kyoto subtemple, and Eugen Herrigel, author of *Zen in the Art of Archery,* are other contributors who should be mentioned. Material from Western authors who are not in contact with Zen, including some of centuries ago who could hardly have heard of Zen, is included to show parallelism in Occidental thought and the Zen branch of Oriental thought.

Zen is, to some, a religion, to others, a philosophy; but it also is a complete way of life. The reason that Miss Ross' anthology can be regarded as a broad introduction to all of Zen is that it is arranged to cover by wide areas virtually all of life. Its contents fall in seven main divisions: "What Is Zen"; "The Essence of Zen"; "Zen in the Arts," including painting, gardens, poetry, ceremonial tea, architecture and the No drama; "Humor in Zen"; "Zen in Psychology and Everyday Life"; "Universal Zen," including Zen-like ways of thinking in the West; and "Zen and the West," applications and impressions of Zen in Western culture. The editor has provided careful, explanatory forewords where needed to explain the applications of Zen in these life areas. In her conclusion she notes: "For the readers of this book the question will hardly arise of becoming a Buddhist, but that does not lessen the importance of Zen to them; for however small the fragment of Zen that makes live contact with the Westerner, its influence is bound to work through, and he will never be quite the same again."

Suzuki's book discusses Zen from the point of what is generally assumed to be its characteristic of greatest interest to the West, its mysticism. He compares, for one thing, the mysticism of the medieval Christian heretic, Meister Eckhart, and that of the Buddhists. He brings out points of difference but many more of resemblance in thought and emotional tone.

Suzuki, Erich Fromm and Richard De Martino discuss Zen and psychoanalysis. Their book is developed from a workshop on Zen Buddhism and psychoanalysis conducted in Mexico in 1957. It is an excellent exposition of the points of contact and contrast in Zen and psychoanalytic therapy. Zen can be thought of in a sense as an existentialist philosophy; and its influence in Western psychotherapy can be compared to that of the Existentialists. It appears to be increasing.

Benoit, French psychoanalyst, devotes his book to a study of Zen from the psychological approach. He too indicates clearly the points of similarity and contrast between Zen and Western psychoanalytic thought. His view is of particular interest because he writes, not as a Zen adept nor as a Western skeptic, but as a Westerner who is developing his own thought within the broad framework of Zen.

Becker is the skeptical critic. He believes that Zen is a negative doctrine and one that holds no value for the Occident. He appears to consider it anti-intellectual. The reviewer, who cannot agree, thinks that Becker is applying Zen aphorisms in a way never intended in Zen philosophy.

The Spirit of Zen, written by Alan W. Watts who is the author of *The Way of Zen,* is a short introduction to the history and theory of Zen philosophy. Watt's interest is apparently primarily in the way of life—or possibly the way of religion—exemplified in Zen. His book originally written in 1935, has been brought up to date with a completely new bibliography. It was intended originally as a popular introduction to Zen and is still an excellent one.

The two remaining volumes reviewed here relate to the history and development of the Zen movement. Dr. Fujisawa writes of Zen and Shinto, contending that Shinto has been largely misunderstood by the Western conquerors of Japan, or rather that a distortion of Shinto by the Japanese nationalists was mistaken for the entire body of doctrine. The author's point of view may be seen in his endorsement of the tenets put forth in a Christian framework by the Reverend Donald Harrington of the Community Church in New York City. Fujisawa takes a decidedly liberal view. The small volume of the teaching of Huang Po is another contribution to the development of Zen. It consists of sermons, dialogues and ancedotes of a great Zen teacher of 1,100 years ago.

Taken as a group, the books here reviewed would serve as an excellent introductory collection to Zen, its philosophy, and its controversial position in the Western world—in particular in relation to Western psychiatry.

The Crisis in Psychiatry and Religion. By O. Hobart Mowrer. 264 pages including index. Paper. Van Nostrand. Princeton, N. J. 1961. Price $1.95.

This book by a well-known psychologist deals with what he considers to be the present-day shortcomings of both psychiatry and religion in alleviating personality disorders which Mowrer feels—as was generally felt some generations ago—are basically due to "real guilt... that can be radically resolved only by confession that has at least a quasi-public character." He is, of course uncompromisingly against Freud, whom he accuses of adopting a Calvinistic doctrine of predestination, whereby the neurotic has no control over his personality development in early childhood, nor any way of recovering from his neurosis in later life. Mowrer feels there should be a form of confession or counseling by the clergyman, who then will be able to decide when his counseling will suffice and when further help is needed. Mowrer's present work is religious rather that psychological, but it is clearly written and an excellent presentation of a little-regarded point of view about which the psychiatrist should be informed.

The Trial of Lady Chatterley. C. H. Rolph, editor. 250 pages. Paper. Penguin. Baltimore. 1961. Price 95 cents.

The Erotic in Literature. By David Loth. 256 pages including index. Cloth. Messner. New York. 1961. Price $5.95.

The Smut Peddlers. By James Jackson Kilpatrick. 323 pages including index. Cloth. Doubleday. New York. 1960. Price $4.50.

The question of obscenity—censorship versus freedom of the press—has received much professional and general attention in recent years; and it has been re-raised very recently by court action in the United States against Henry Miller's *Tropic of Cancer.* (This novel is reviewed elsewhere in this issue of The Psychiatric Quarterly.)

The books under present consideration cover the history in England of the recent *cause célèbre* involving D. H. Lawrence's *Lady Chatterley's Lover* and discussion of the laws on the general subject. *The Trial of Lady Chatterley* is a report of the British procedure aimed to suppress the famous novel. The decision was much in line with that handed down previously by a United States federal court. The book was ruled not obscene, and the reasoning in the British case followed closely that in the American. The book's editor—he presents a transcript of the trial—is an author, speaker and editor thoroughly acquainted with the circumstances. His report is readable and important, and the reviewer suggests that it would belong in the "Famous British Trials" series, except for lack of a murder. It is an important publication for all who are interested in social science or forensic medicine.

In *The Erotic In Literature* Mr. Loth, a publicist and writer, covers the question of pornography from remote times to the present, discussing the law, citing instances and proposing for present action the abolition of the obscenity laws as "a menace to the society they are supposed to protect." Loth would replace law by informed community standards. He thinks this might result in lurid material on some newsstands but "less smut in candy stores across from public schools." In summarizing, he says: "Readers inevitably identify themselves with favorite characters in fiction. Realistic behavior by these characters, which is virtually impossible under the present rules for men and women in novels, would tend to rid their flesh-and-blood admirers of some psycho-sexual fears and tensions. This might even weaken the national preoccupation with sex, mammalian appendages, and potency."

Kilpatrick's discussion of *The Smut Peddlers* is primarily concerned with material that has no pretensions to being literature. A newspaper editor, he reviews the history of legal and social efforts to suppress "obscenity." As a newspaperman, he is plainly on the side of freedom of the press in general, but he feels that the problem as a whole "is the familiar one of weighing conflicting values. . . .I have a right to publish; society

has a right to protect itself from overt obscenity. At what point do my rights and society's come in conflict?" Kilpatrick thinks the actual damage caused by successful obscenity prosecutions "to writers who would write about sex," has been greatly exaggerated. He says, "I cannot conceive that their liberties have been seriously infringed." He seeks a middle ground, without too many specific recommendations, but with an evident leaning toward local sales regulation.

Much psychiatric material, of course, deals with sex. It is not at all inconceivable that some day it may come under attack as "obscene." This general problem, therefore, is of particular concern to psychiatrists.

Odyssey of the Self-Centered Self or Rake's Progress in Religion. By Robert Elliot Fitch. 184 pages. Cloth. Harcourt, Brace & World. New York. 1961. Price $3.95.

This book, by the dean of the Pacific School of Religion, a Congregationalist, employs the apparatus of Burton and, as in *The Anatomy of Melancholy*, one tends to be distracted from the argument by the references and illustrations. There is, however, a hidden pitfall in Democritus Jr.'s effort which is less cryptic in Fitch's. Having moved beyond the days of the encyclopedists and come upon the era of compartmentalized knowledge, the contemporary would-be generalist is often grounded by lack of specific information. This is Fitch's difficulty. He has entered territory which is about as difficult and troublesome as it is possible to find; and he has merrily laid about him without any indication that he is aware that the experts in the field are in agreement that his avowed target can only be made discernible by rigidly disciplined effort and the use of accepted definitions. The words Fitch uses for the self (self, ego, me, reality of myself, god, One True God, you) and the context in which he speaks of it make it clear that his effort must remain that of a dilettante. There is no evidence that he has heard of Janet, or even James. His book is provocative rather than definitive, diverting rather than important.

Even if one grants Fitch the professional preacher's privilege to be vague, the material he employs in his apparatus is peculiar in some important respects for an advocate of outward-directedness. It is not unusual for writers in this area to be weak in science but Fitch has managed to cover his subject without reference to any of the Rhineland mystics or even to St. John. He completes a very odd logical somersault by rejecting Oriental world-soul concern as self-centered but in accepting Occidental resignation as outward-directed.

The jacket advertises the book as "witty and sophisticated," "by the author of 'The Decline and Fall of Sex.'"

Development of the Perceptual World. By CHARLES M. SOLLEY and GARDNER MURPHY. 353 pages. Cloth. Basic Books. New York. 1960. Price $6.50.

Motivation is a central problem in psychiatry as in psychology. Why do people not do what they might, when it is (apparently) obvious that they would be better off if they did? Or, "Why are people so short-sighted?" Or, "Why do some people respond by seizing opportunity for present pleasure when it would be wiser and ultimately more profitable to forego the present pleasure for satisfaction of the future?"

According to points of view which regard autism as a form of self-satisfaction, rather than as a consequence of afferent deprivation, the answer to such questions leads to emphasis upon the positively perverse element in the course of action. One asks not, "Why do people not act wisely?" but rather, "Why do people persist in acting unwisely?" In the present book, and despite its title, Solley and Murphy seem more interested in searching out the springs of motivation than in evaluating the substrate of perception. The authors are frankly interested in the development of a theoretical synthesis of material which has been drawn almost exclusively (although there is some Malinowski material) from the psychologic and interpretative psychiatric literature. There is no insistence on any particular "school"; the approach is relaxed and eclectic; and the authors formulate a theory of learning based upon their approach to the process of perception. The reviewer finds some difficulties in attempting to rephrase this theory, simply because the real purpose of the book is to present a theory of perception in terms of learning rather than one of learning in terms of perception. However, whatever position one may adpot here, it is impossible to read the book without enlarging one's horizon and encountering many provocative ideas.

Man's Presumptuous Brain. By A. T. W. SIMEONS. 290 pages. Cloth. Dutton. New York. 1961. Price $5.75.

The author of the present book is said to be a general practitioner who has come to the conclusion that "psychosomatic disorders arise from the unnecessary and unequal struggle between man's ancient drives and human goals." As the writer of the foreword observes, this is not a new idea. The *raison d'être* of Simeons' book must therefore rest upon some special quality which is described as readability by the layman for whom it is intended. The book is divided into "The Evolution of Man," "The Evolutionary Background of Some Psychosomatic Disorders," and "An Outlook." The level of factual material will not satisfy the professional, but it does seem as if this might be a useful book for persons who have a little biological training in their background.

In Your Opinion. By JOHN M. FENTON. 220 pages. Cloth. Little, Brown. Boston. 1960. Price $3.95.

The managing editor of the Gallup Poll herein reviews the last decade and a half of Americans' reactions to big and little issues of the day. Feelings about Truman, Eisenhower, McCarthyism, and segregration, as well as about such problems as Dior's "New Look" in fashions, and how many more Republicans than Democrats have taken the road to Miltown, are assessed and interpreted in traditional reportorial writing. Despite the highly "scientific" statistical chance sampling selection, the use of IBM cards and electronic computers, only 1,500 voters are questioned on a particular issue, and it is estimated that each one thus polled is, in effect, speaking for 69,000 of his fellows. With the variety of personal-cultural factors affecting public opinion, this leaves serious margin for error. Fenton tries bravely to account for the notorious distortion of the Gallup Poll in predicting the outcome of the 1948 election. Although not so completely objective as it purports to be, the book does make interesting reading for those who want a bird's-eye view of this period.

Social and Cultural Pluralism in the Caribbean. VERA RUBIN, editor, and 15 authors. 155 pages. Paper. New York Academy of Sciences. New York. 1960. Price $3.00.

The tradition of assimilation which, with the exception of certain areas, is supposed to have characterized society in the United States, has, within recent years, gradually yielded to the historical alternative of pluralism. Although the concept of the "plural society" (co-existence of different societies, without assimilation, in the same political community) has only become popular in recent sociologic writings, the fact of pluralism is as old as history and has characterized more cultures and areas than has assimilation. Even in the United States, and in areas where the democratic tradition has been subjected to less stress than elsewhere, pluralism has often been the fact and assimilation only the theory.

The dynamics of such pluralistic systems form a large part of the traditional material of sociology, but it always seems to be easier to understand the operation of common principles in societies outside those with which we are personally identified. The present study affords that opportunity, but there are other good reasons for being concerned about Caribbean phenomena. Not only must we understand what is occurring in this critical area, which forms one of our important thresholds, but many of the social practices of the Caribbean are being transported into those of our areas which have traditionally operated as the melting pots of the United States. The present volume is a valuable aid in arriving at an understanding of the social forces which are operating in the Caribbean.

Tropic of Cancer. By HENRY MILLER. 318 pages. Cloth. Grove. New York. 1961. Price $7.50.

Henry Miller's famous *Tropic of Cancer,* published in the United States after many years of suppression, has come promptly into conflict with the law. It has been extravagantly praised and as extravagantly attacked. The book is a fictionalized supposedly autobiographical report of a stay in Paris, largely in the slums, some 30 years ago.

To this reviewer's mind, this book has been tremendously overrated. He has no desire to depreciate the excellence of the writing or the vividness of the author's scenes. The book, however, purports to be a report of a period in an apparently schizoid young man's life. It is supposed to be written without prudery or restraint. It is confined, however, largely to psychopathic sex adventure and to preoccupation with the assorted miseries of vagabondage and slum dwelling. It seems to the reviewer to be as selective in this direction as any drawing-room comedy is in the opposite. There is much dwelling upon anality of one kind or another, and much immaturity in the discussion of sex and of women—whom the principal character's friends at least seem to regard as creatures designed solely for sensual pleasure. The reviewer does not believe that this is a fair picture of life, even under the given circumstances.

At the same time this reviewer does not believe that this book should be suppressed. The general question of censorship aside, this is not a novel to appeal to adolescents. It is tough reading, and is often revolting. In the reviewer's opinion, it could do less harm at its utmost than any one of dozens of readily available comic books. It seems to the reviewer that this is one place for application of the declaration of principle paraphrased from Voltaire: "I disapprove of what you say, but I will defend to the death your right to say it."

Culture, Society and Health. VERA RUBIN, conference editor, and 42 authors. 275 pages. Paper. New York Academy of Sciences. New York. 1960. Price $3.50.

Vera Rubin observes, in the preface of this monograph, that "the conference on culture, society and health was organized to promote the integration of medical and social science findings toward increased understanding of the social ecology of disease and a unified concept of the human being in his natural and cultural environment."

The 275 pages in the monograph are allocated among four sections. These are sociocultural factors in (1) chronic organic diseases (2) mental illness and public health programs (3) chronic disease and research perspectives in medicine and social science and (4) panel discussions (30 pages) on research, mental illness, chronic organic disease, fertility and public health.

Crime in America. HERBERT A. BLOCH, editor. 355 pages. Cloth. Philosophical Library. New York. 1961. Price $6.00.

Crime in America is a somewhat ambiguous title. Much of the book in hand really deals with correctional processes and law enforcement. It consists of more than 20 chapters by different writers who are concerned with subjects which, while interesting, have no particular continuity or central theme. Some of the material, such as that covered by Hacker and Frym ("The M'Naghten Rule and Legal Insanity"), or by P. A. Roche ("Psychiatry and the M'Naghten Rule"), or by Zarrilli ("Homosexuality and Prostitution") has been reviewed so many times that the only excuse for doing it again would seem to be inclusion in a systematic and comprehensive text (neither of which this is).

New material is, however, included in articles such as that by Tasher on "The Maximum Security Beatty Memorial Hospital," by McNamara on "Crime and the Labor Movement" and Schmideberg on "The Child Murderer."

There is almost no statistical material and there is no discussion of the odd condition of statistics on crime in places such as New York City and New York State. There are no accounts of rape, vandalism, fraud or counterfeiting. Smuggling is not discussed, and no recognition is afforded of the daily accounts of crime on the bench and among law enforcement officers. Crime in relation to insurance is not discussed. The fraudulent activities of advertisers, agencies and public officials are ignored. Bloch comes close to fundamental issues in a terminal article on gambling in which he observes, "The fact remains that many of our 'lesser' problems, so-called, constitute the real basis for the major problems we face."

It is unfortunate that this terminal observation was not made the central theme of a systematic treatise. Such a study is needed more than the present book.

No subject index has been provided.

Psychology of the Child in the Middle Class. By ALLISON DAVIS. 70 pages. Cloth. University of Pittsburgh Press. Pittsburgh. 1960. Price $1.85.

This is the eighth annual Horace Mann lecture in education, and is a brief essay analyzing the crucial role of social status and achievement in the development of the middle-class personality. The author explores the possible ways for the child to handle the hostility arising from the restrictions and demands of parents and society. Anxieties, best relieved by striving and competition, are conceived therefore as positive forces and essential to the most successful people, those who "get ahead." This is of great interest at this time, when so much psychological research is being spent in exploring the effects of anxiety in school children.

Tactics of Scientific Research. Evaluating Experimental Data in Psychology. By MURRAY SIDMAN. 428 pages. Cloth. Basic Books. New York. 1960. Price $7.50.

The subtitle of this work is more informative than the title. Murray Sidman is a psychologist who has been active in the field of operant behavior, and his book is primarily oriented toward the young investigator engaged in such work. The specialized terminology of the author's field is carried forward in the book and impairs easy intelligibility for the general reader. Sidman displays a trick of communication which characterizes much writing in his field. This is a forebearance from interpretation—the withheld, implied conclusion, it might be called. This methodology has arisen in circles which have become dissatisfied with an easy complacency with generalization and especially with the substitution of symbols for phenomena. It entails, however, a great risk—that of unproductivity.

From Lenin to Khrushchev. By HUGH SETON-WATSON. 432 pages. Paper. Praeger. New York. 1960. Price $1.95.

The original edition of this book was published in 1953 under the title "From Lenin to Malenkov." The present edition has had two chapters added to bring it more up to date. The author stresses that this book is not a complete study of Communism, explaining that Communism is a theory, a vocation, a conspiracy, a revolutionary movement and a historical phenomenon.

Many books have been written on each aspect of Communism. This one deals mainly with the historical phenomenon. The translation suffers at times from faulty idiom. The text is somewhat repetitious, but the material is well-documented and exhaustive. This book can fill a need for general historical knowledge.

An Introduction to Social Psychology. By WILLIAM MCDOUGAL. 527 pages. Paper. University Paperbacks. New York. 1960. Price $1.95.

This book was first published in October 1908, and has been reprinted 30 times. There are at least 23 revisions and several chapters were added to the original book. The author himself stated that this was the most originally productive of his many writings.

The book is more philosophical than psychological, stressing the introspective method which the author disclaims at the beginning. As an expression of an intermediate point of view in the development of psychology, it is well worth study by students. It is well-written and readable, although somewhat repetitious.

Education For Living. By JACOB SAMUEL LIST. 112 pages. Cloth. Philosophical Library. New York. 1961. Price $3.50.

The List Method of Psychotherapy. 258 pages. Cloth. Philosophical Library. New York. 1960. Price $7.50.

These two books purport to describe the List Method of Psychotherapy. Dr. List is an educator, and it is his belief that an educator is better qualified to do psychotherapy than a psychiatrist. It is surprising how many nonmedical individuals profess to know more about psychotherapy than the entire medical profession, and assume that, because certain illnesses are on an emotional basis, this covers the entire gamut of emotional disease. The List method purports to use Freudian concepts but to add "something more." The something more is described by List as warmth, a liking for people and allowing the personal life of the therapist to mix with that of the patient. Actually, his entire description covers the use of inspirational and authoritarian approaches. He states that his first therapists were former patients, but later says that his therapists have undergone Freudian analysis.

The second book on his method of therapy is written by some of his therapists and in most cases, is a superficial review of various aspects of the application of the List method. The therapists stress the group milieu, education, relationships of the family, and the personal participation of the therapist. The chapter on sexual inversion certainly adds nothing to our knowledge of homosexuality and gives the impression that the List method attempts only to make the homosexual happy with his homosexuality.

List's patients are highly selected, as he states that he cannot work with a patient if he does not like him. In one chapter, the author uses approximately a dozen cases to prove that education is an active form of therapy. There is no question, of course, that inspirational and authoritarian approaches with proper personnel and selected cases yield satisfactory results. As a general method of therapy based on sound scientific and medical principles, the authoritarian method fails.

The Tough and Tender. By ANGUS MACLEAD. 192 pages. Cloth. Roy Publishers. New York. 1960. Price $2.95.

A mystery story, placed in a small Scottish village, is so badly and boringly executed that this reviewer thinks that not even devotees of the genre could take it.

The Natives Are Restless. By CYNTHIA LINDSAY. 223 pages. Cloth. Lippincott. Philadelphia. 1960. Price $3.95.

This examination of Southern California may not appear on a sociologist's reading list, but it is a delightful book filled with interesting information and anecdotes which are downright funny.

The Psychogenesis of Mental Disease. By C. G. JUNG. Coll. Works Vol. 3. Bollingen Series XX. Translated by R. F. C. HULL. 312 pages including index and listing of works by author in this series. Cloth. Pantheon. New York. 1960. Price $4.50.

Half of this excellent volume is devoted to Jung's very early and important work, *The Psychology of Dementia Praecox,* which was first published in 1907. It is presented here in a new translation along with other articles of considerable value, including two papers which were written in 1956 and 1958. The whole of the book reflects the development of Jung's thinking through the years on the nature of mental illness. It seems that room should now be made on the psychiatrist's shelf right next to the important volumes by Bleuler and Arieti.

My Unwelcome Guests. By FREDRICK S. BALDI, M.D. 222 pages with selected bibliography. Cloth. Lippincott. Philadelphia. 1959. Price $3.95.

This book is the professional autobiography—with numerous anecdotes—of a man who started out to be a prison doctor but became a prison administrator instead. His selected bibliography includes a number of psychiatric and psychoanalytic works; he had a "tour of duty in the psychopathic wards" of Philadelphia General Hospital before beginning his prison practice; and his early assignments included making mental examinations of prisoners; but he does not appear to set a high value on psychiatry, either in criminology or in forensic medicine; and he pronounces numerous personal verdicts that this convict or that was "sane" or "insane." His viewpoint is that of the tough, "common-sense," but generally humane, administrator; his book is written for the general public; but almost anybody concerned with criminology might profit from reading it.

Medicine and Anthropology. The March of Medicine No. XXI. IAGO GALDSTON, M.D., editor. 165 pages. Cloth. New York Academy of Medicine Lectures to the Laity. International Universities Press. New York. 1959. Price $3.00.

The lectures to the laity included in this volume are as valuable to the professional as to the layman, as they impinge on areas of anthropological field work, sociology, social psychiatry, acculturation and higher education in which most medical men are themselves laymen. Of particular interest to the psychiatrist are the contributions of Paul Fejos, medical doctor turned anthropologist; Alexander H. Leighton, M.D., who is professor of sociology at Cornell; and Marston Bates, professor of zoology at Michigan. Bates' lecture on the ecology of health is unusually stimulating, although he arouses this reviewer at one point to the temerity of violent disagreement with a zoologist about zoology. This book is recommended for any medical library.

Homosexual Intrigue. By WING'ED SOUL. 122 pages. Paper. Western Voice Publishers. Englewood, Colorado. 1961. Price $1.00.

This is stated to be an autobiography, obviously under a fantastic assumed name, of a teacher of English (his grammar makes this difficult to believe) who was persecuted by a ring of homosexuals. His chief character, William, tormented as a mama's boy in school in his home town of 150,000, inhabited by the "lowest form of the human race," later runs into a conspiracy to railroad him to a mental institution and still later a conspiracy of homosexuals and other "perverts" in the town and county where he is teaching; they finally drive him from his job. William displays much religiosity of an extreme fundamentalist type; and he sets down a number of rules by which a homosexual who wants to be normal can overcome his "mental quirk": "Go for a brisk walk . . . Exercise strenuously . . . Practise on a punching bag"—all of which recall the advice to Elmer Gantry, in the face of heterosexual temptation, to go out and "run like hell."

This book is privately printed by the reproduction of typewritten pages. It should have considerable interest for the psychopathologist and might even be used as collateral reading in a teaching course.

The Sixth Man. By JESS STEARN. 286 pages. Cloth. Doubleday. New York. 1961. Price $3.95.

Jess Stearn, an experienced newspaperman, makes a 286-page tour, interviewing the homosexual on his own grounds. He provides good descriptions of the emotional entanglements that the homosexual experiences in daily living. He also gives excellent material on the values placed in homosexual circles on education, social standing, place of employment and home. He reports the familiar homosexual arguments that homosexuals should be accepted as the third sex and be allowed in society as such. Being accepted as a third sex, they feel they would be free of blackmail, police and public resentment and persecution. Stearn naïvely accepts the homosexuals' own estimate that they number one of every six men in the country; and, except for the George Henry Foundation and Dr. Henry himself, he seems to take little account of psychiatry and psychiatrists.

This reviewer feels that the book is interesting and informative about the behavior and social customs of the better-educated homosexual; but it will not help the general reader to understand the problem; and it may present some danger to the susceptible by overstressing the homosexual's defense and overestimating the incidence of the aberration.

The Mill. By BRADLEY ROBINSON. 407 pages. Cloth. Random House. New York. 1961. Price $4.95.

The reviewer found this an unreadable novel. It concerns the moral degradation of mill workers in a New England community; and the author fails in his story, not to mention his lack of psychological insight.

Psychology of Literature. A Study of Alienation and Tragedy. By RALPH J. HALLMAN. 262 pages. Cloth. Philosophical Library. New York. 1961. Price $4.75.

The prospective reader is likely to be puzzled by the title of this work, and more so by the statement that the author is chairman of the social science department, Pasadena City College, California.

For the psychiatrist, the subtitle, "A Study of Alienation and Tragedy," offers additional semantic traps. In point of fact, Hallman's professional position has no very direct bearing on this production, which, as the cover says "presents a unique, non-Aristotelian theory of tragedy as it occurs in both life and literature. It traces the roots of tragedy to their psychological origins and finds them to consist of certain alienating forces which endanger individual autonomy."

The author suggests that the tragic experience rises out of the primitive need to die and to be reborn as the only means of maintaining an integrity. But the emergence of a self-criticizing intellect alienates man by presenting death as necessary but meaningless. The tragedian, however, can preserve a spontaneity in living situations by substituting artistic meaning.

This is not a wholly new theme and Hallman's handling of his subject has the slightly extravagant air of the amateur in any particular field. He has, however, thought hard and long about his subject, and has done his best to impart his emotional experiences to the reader.

The Motivation of Behavior. By JUDSON SEISE BROWN. 404 pages. Cloth. McGraw-Hill. New York. 1961. Price $7.50.

This work by Professor Brown (University of Florida) is intended as a textbook in the psychology of motivation theory. It forms an element in the textbook sequence in this field known as the "McGraw-Hill Series in Psychology," which is now edited by Harry Harlow. These books would seem to be chosen on the assumption that commitments already exist as to their use as textbooks within a certain orbit, and they are priced high in terms of what their production cost might be.

Brown's contribution to the series is a common-sense application of Hull's multiplicative-drive theory, and it reflects Hull's interests. With this body of material is a sort of addendum which is concerned with procedures such as brain stimulation and conditioning. This is the weakest part of the book, but Brown has avoided a deep commitment to monocular considerations such as reward-site theory.

While this contribution does not cover all the areas of interest to the psychiatrist, or attack some of his most urgent problems (such as motivation in amoral behavior), it is a reliable introduction to the present state of the academic approach to a large part of the field of motivation.

Becoming More Civilized. A Psychological Exploration. By LEONARD W. DOOB. 333 pages. Cloth. Yale University Press. New Haven. 1960. Price $6.00.

This is an important book on problems of great importance to the psychiatrist, and especially to the psychiatrist who is called upon to adopt a position with regard to the rapidly emerging nations of nonliterate societies. Professor Doob (psychology, Yale) has worked in East Africa and South Africa and develops a series of principles (which, after the fashion of the literature in psychology, he calls hypotheses). The critical reader might denigrate Doob's efforts on the ground that he tends to beg the question or that his hypotheses are self-evident, but the present reviewer feels that in an area where political configuration has the stability of patterns in a kaleidoscope it is reassuring to find the self-evident confirmed. Some of Doob's hypotheses can (with some violence) be condensed as follows:

In comparison with those who remain unchanged or who have changed, people in the actual process of changing from old to new ways are likely to be more discontented, to feel more aggressive, to be more tolerant of delay in the attainment of goals, to feel more ambivalent toward outsiders associated with those new ways, to be members of newly established groups of similarly behaving persons, to be more proficient in novel situations and to be generally sensitive to other people.

People changing from old to new ways are likely to retain traditional attitudes toward family forms and practices and to feel antagonistic toward traditional leaders who do not reveal changes similar to their own.

After people change to new ways they are likely to value traits which indicate independence, to be dogmatic concerning value judgments, to develop facility in abstracting, to be more proficient in making judgments of time intervals and to become more proficient in verbal expression.

In some respects Doob's material seems so simple and obvious as to verge upon unsophistication, but the present reviewer has the feeling that this book might well be used as a text for personnel destined for service in emerging areas. Judging from the reports which reach one through the Society for Academic Freedom, the obvious is not so well known and appreciated in Africa as to have become superfluous.

Basic Principles of Psychoanalysis. By A. A. BRILL, M.D. 318 pages including index. Paper. Washington Square Press, Inc. New York. 1960. Price 60 cents.

This book was originally published by Garden City Books (Doubleday) in 1949.

The author gives a clear description of the first psychoanalytic theories and methods. Its style and fluency make it easy for the reader to understand the principles set forth.

Science and the Structure of Ethics. International Encyclopedia of Unified Science. Vol. II. Foundations of the Unity of Science Number 3. By ABRAHAM EDEL. 101 pages. Paper. The University of Chicago Press. Chicago. 1961. Price $2.25.

Edel's purpose is to prove that the almost universally accepted position of scientists (that no relation exists between science and ethics) is wrong. He immediately abandons the familiar effort to attempt to derive ethics from science and turns to the device of attempting to contain science by applying evaluative judgments derived from the social sciences. This is, of course, the familiar technique of historians who, like Barzun, find C. P. Snow's proposition of two worlds highly repugnant since it leaves *them* out in the cold. Edel makes it clear at the onset that he intends to make science behave by applying the logical device of evaluating scientific results, method, and what he calls the "impact of the scientific temper," all in terms of ethical theory. The effect of this logical inversion is, of course, to abandon demonstrative evidence as the factor compelling acceptance.

In place of this, logical criteria are laid down. Edel, then, begins by begging the question and setting up rules which allow for an infinite variety of manipulations. Not many persons will have the patience to follow through the variations which Edel develops. Those who do may be surprised to find that he emerges with the conclusion that ethical theory can profit by the application of scientific methodology. The scientist (for whom the *International Encyclopedia for Unified Science* is presumably intended) will probably be disappointed to find that he has been put to a great deal of effort to follow Edel's arguments, only to emerge with a consideration which is not really of any concern to him. If, however, he has followed the development of this series thus far, this will not be a novel disappointment.

Foundations of Psychopathology. By JOHN C. NEMIAH, M.D. 338 pages including index. Cloth. Oxford University Press. New York. 1961. Price $6.50.

This text is intended as an introduction to the principles of psychopathology. The entire work is based on psychoanalytic teachings; however, the author admittedly stakes no claim for completeness. It is clearly written, and the style is interesting and appealing; the beginning student and interested lay persons will probably find valuable the extensive reliance on illustrative material such as quotations from interviews with patients, autobiographical sketches and selections from certain literary works.

The Masker. By JEAN RENVOIZÉ. 224 pages. Cloth. World. Cleveland. 1961. Price $3.95.

A rather boring British novel concerns a television "personality," a blocked writer, promiscuous and confused. Hero and author alike misunderstand the central problem of his neurosis, the reviewer thinks.

Escape From Authority. By JOHN H. SCHAAR. 349 pages including index. Cloth. Basic Books. New York. 1961. Price $6.50.

At last, here is a major work dedicated to the critical analysis of Erich Fromm's philosophical orientation. The author's penetrating assessment will invite discussion and, in certain quarters, considerable argument; it should in any case be well received as a careful, lucid and astute examination of Fromm's work.

Prehistoric Religion. By E. O. JAMES. 300 pages including index. Cloth. Barnes & Noble. New York. 1961. Price $6.50.

The Cult of the Mother Goddess. By E. O. JAMES. 300 pages including index. Cloth. Barnes & Noble. New York. 1961. Price $6.50.

These volumes are re-publications of excellent and highly condensed books on various aspects of ancient religion, written by an eminent British authority. They were first published in this country in 1957 and 1959 respectively and were reviewed in THE PSYCHIATRIC QUARTERLY at those times. They are both valuable introductions to material which, as James observes, although far in the past, "is contained in the present."

Prehistoric Religion covers matter as far back as the man of Choukoutien. *The Cult of the Mother Goddess* chronicles rituals which date from the far past and still have representation in the present. Both books are worth a place in the "background library" of any social scientist.

The Annual Survey of Psychoanalysis. Volume VI. JOHN FROSCH, M.D. and NATHANIEL ROSS, M.D., editors. 612 pages including index. Cloth. International Universities Press. New York. 1961. Price $12.00.

Volume VI, the 1961 issue of *The Annual Survey of Psychoanalysis,* covers the year 1955. As a writer for a journal which has had more than a little difficulty in attempting to bring its press times up to date, the reviewer sympathizes with the efforts of the editors to narrow the gap between the original publication of the literature and the publication of *The Annual Survey.* A delay of six years, nevertheless, is far too long for the practitioner who wants to use this volume as a guide in keeping abreast of the literature, although it does not impair its value as a reference work.

The reviewer is aware that criticism have been justly leveled at the quality of the descriptions and condensations represented in these volumes, but the difficulty of abstracting accurately or even giving brief accurate descriptions is almost insuperable. The present issue can be used readily by anyone wanting a general account of the course and progress of psychoanalysis for the year it covers. As the numbers of these volumes increase, their value as reference works is, of course, enhanced. The reviewer thinks they would be of worth as a reading guide—if for nothing else—in almost any library covering psychoanalysis.

The Frog Pond. By JOYCE MACIVER. 412 pages. Cloth. Braziller. New York. 1961. Price $4.95.

It has become customary for scribbling ex-patients, dissatisfied with their psychotherapists, to air their unresolved "resistances" in public. In the present case, this is aggravated by what appears to be malice extraordinary and sexual sensationalism. The author, using a pseudonym, attacks her first five therapists, whom she seems to have left in various phases of resistance, finally giving credit to the sixth who "cured" her—through deep breathing! The deep-breathing specialist's therapy is not described in detail, although the author spends dozens of pages attacking her "unsuccessful" previous therapists—a matter suggesting to this reviewer that her motivation includes hatred. The author, furthermore, upbraids one of the unsuccessful five as cruel, because he pointed out to her that she wanted and liked punishment. Then, without seeing the contradiction, she confesses in the narrative to the wish as an adult to be beaten, and to going to great lengths to find a group of perverts to satisfy the craving. In addition, rather crude talk about sex dominates the pages of what the reviewer considers a substandard book.

Sex Ways in Fact and Faith. Edited by EVELYN and SYLVANUS DUVAL. 253 pages. Cloth. Association Press. New York. 1961. Price $3.95.

Fifteen contributors deal with religious attitudes toward sex and statements of people working in the field of sex education. The book is not uniform; interesting contributions (e.g., Wynn's "What Churches Say Today") are interspersed with dubious ones. In the latter group, belongs a contribution of W. P. Pomeroy, a collaborator of the late Dr. Kinsey, in which one can read the amazing statement: "On the other hand, there is sound argument for the belief that masturbation in marriage may strengthen the marriage relationship in various ways... If the sexual levels of the marital partners differ, as it often is the case with usually the male wishing a higher rate of coitus, masturbation may well serve as a balance wheel and help sexual compatibility." A strange attitude is also visible in a contribution of Evelyn Hooker in a "study" on homosexuality.

Handbook of Research Methods in Child Development. PAUL HENRY MUSSEN, editor. 1061 pages including index. Cloth. Wiley. New York. 1960. Price $15.25.

The primary aim of this handbook is to make available in one volume the various techniques that are being employed in research in the field of child development. The detailed descriptions are clear and the critical evaluations of the research methods presently being used mark this book as a basic reference work and a welcome guide for professional investigators and advanced students.

A Social History of the American Family. Three volumes. By ARTHUR W. CALHOUN. Vol. I—Colonial Period. 400 pages. Vol. II—From Independence Through the Civil War. 443 pages. Vol. III—From 1865 to 1919. 411 pages. Paper. Barnes & Noble. New York. 1960. Price $1.75 for each volume.

The statement which appears on the cover of this Barnes & Noble reprint of a great book is concurred in by the present reviewer. It reads, "A Social History of the American Family, since its first publication (1917-1919), has become a classic in the field because of its profound and definitive treatment of the subject. Volume I discusses the influences of the European background on American family life and shows how these influences were modified or overturned by the New World environment. Volume II traces the effects on the family of the frontier in the West, the rise of urban industrialism and the growth of wealth in the North, and the slave regime in the South. Volume III covers the period from Reconstruction through the First World War, analyzing the consequences of the advance of industrialism and capitalism, urbanization, large-scale immigration, reform movements, and scientific family study."

A particularly valuable feature of this work is its elaborate and comprehensive index.

Calhoun saw the "decay" of the American family with startling clarity. Time has justified his concern. Instead of a remedy it has brought further dissolution. It is doubtful whether any American who is ignorant of the contents of these volumes can truly be said to be educated.

Psychophysiological Reactions to Novel Stimuli: Measurement, Adaptation and Relationship of Psychological and Physiological Variables in the Normal Human. By ROSCOE A. DYKMAN, WILLIAM G. REESE, CHARLES R. GALBRECHT, and PEGGY J. THOMASSON. 64 pages. Paper. New York Academy of Sciences. New York. 1959. Price $2.50.

This pamphlet comprises a report from the Laboratory for Behavioral Research of the Department of Psychiatry of the University of Arkansas Medical Center. It deals with a research in which medical students were examined with regard to skin resistance, heart rate and respiration, in order to determine what changes occurred when they were asked questions with variable affective content. It was found that skin resistance was the most reliable measure, that the magnitude of the response is inversely variable to the height of the initial level of functioning and that tense persons "tend to operate at higher autonomic levels" (this sounds as though one were saying merely that tense persons tend to be tense!). So do the intellectually proficient and those who deny abnormality in themselves.

The Three-Dimensional Personality Test. By LEAH GOLD FEIN. 324 pages including bibliography. Cloth. International Universities Press. New York. 1960. Price $6.75.

When Dr. Fein first worked with the 3-DPT she "realized that the material being tapped by the 3-DPT forms derived from a deep layer of [her] personality, a layer that had been closed off from conscious concern by comfortable rationalizations. No other projective test had given [her] such insights so quickly and so convincingly during a personal testing session." It was at that moment that she decided to study the 3-DPT. Her efforts at standardizing the test, establishing norms, offering interpretative insights and statistical analysis are brought together in this text. Research psychologists will not be happy with the design of her study and the presentation of statistics, and clinicians who are not rigidly Freudian will certainly wonder about the symbolic significance of many of the forms. Perhaps more work has to be done with this test before it is to become "an indispensable tool" for the clinical psychologist.

Festschrift For Gardner Murphy. JOHN G. PEATMAN, PH.D., and EUGENE L. HARTLEY, Ph.D., editors. VII and 411 pages. Cloth. Harper. New York. 1960. Price $6.00.

This book, a collection of studies and essays by former students and associates of Gardner Murphy, is presented, as the title indicates, as a *Festschrift* to Gardiner Murphy on his sixty-fifth birthday.

The breadth of the topics covered—learning, social theory, death, ESP, perception, nationalism, psychotherapy, education, values, psychosomatic medicine, etc.—is a reflection of the broad interests and depth of vision of a man whose influence on American psychology ranks with that of Freud and James. In an era of specialization, Gardner Murphy stands as a modern-day version of the Renaissance *Uomo Universale*. This book is highly recommended not only for the intrinsic worth of the separate studies and essays, but also for its usefulness in providing insight into the mind of a man, who, as his colleagues characterize him, was, "born in the nineteenth century, a product of the twentieth and indeed a citizen of the twenty-first."

1/3 Of An Inch of French Bread. By H. L. NEWBOLD. 243 pages. Cloth. Crowell. New York. 1961. Price $3.95.

An instructor in neurology and psychiatry at Northwestern University School of Medicine attempts in this novel to reproduce the thoughts of a schizophrenic young woman undergoing shock treatment. He is only partially successful; and it is interesting that the neurotic difficulties of her husband—suffering from a compulsive cleanliness complex—appear much more vividly. It is possible that the task the author set for himself is nearly impossible.

The Role of Speech in the Regulation of Normal and Abnormal Behavior. By A. R. LURIA. IX and 100 pages. Cloth. Pergamon. New York. 1961. Price $8.50.

This monograph is concerned with work done up to 1958 in the USSR and reported in a lecture by Luria in London in that year. The data were obtained largely by the study of reaction patterns to stimulus variations, in which the experimental situation is or is not verbally explained to the subject and, if explained, is emphasized in various ways.

Disorders of the Emotional and Spiritual Life. By W. L. NORTHRIDGE. 130 pages. Cloth. Channel Press. New York. 1961. Price $3.00.

The author of this practical little book is a Protestant minister who has managed to accumulate a good deal of first-hand knowledge about affective disturbances. Although he makes no pretense of coping with mental illness he knows the signs of malignant disorder when he encounters them, and has an experienced wayfarer's respect for them. Northridge's terminology is not exactly that of the *Standard Nomenclature*, and his phraseology and style are both a bit on the old-fashioned side; but this reviewer considers these qualities to be virtues rather than handicaps in an area where it makes little difference to a sufferer what name is given to his ailment if he obtains relief. Northridge packs a lot of useful information into his book, which is safe for direct lay consumption.

Geochronology of Rock Systems. J. LAURENCE KULP, conference editor. 78 authors. 433 pages. Paper. New York Academy of Sciences. New York. 1961. Price $5.00.

As everyone is well aware, the development of new techniques for dating the mineral and carbon-containing materials of the earth is responsible for a considerable part of the current widespread interest, not only in geology, but in other sciences as well. Biologic processes and the artefacts of cultural anthropology can now be placed in a much more reliable frame of reference than previously. The present volume contains the material presented at a symposium devoted to mineral systems. The geographic areas considered are almost world-wide and several review charts and maps of early time scales are presented. While highly technical, the presentation can be easily understood by the geologist-layman who is likely to be fascinated by the subject as an abstract intellectual exercise.

It is always of interest to observe how workers in other fields deal with the problem of validation of their own data. The permissive attitude which prevails among geologists in the presence of a relatively high order of quantitative agreement ($\pm$2-3 per cent) must be a source of envy to those of us who are forced to deal with data upon which there is even poorer agreement about qualitative identity.

Stroke. By DOUGLAS RITCHIE. 192 pages. Cloth. Doubleday. New York. 1961. Price $3.50.

Ritchie, a former BBC official, presents here an account of his personal experiences as the victim of a severe hypertensive cerebral thrombosis. The book presents data of importance for all physicians, especially for neuropsychiatrists and those engaged in physical medicine. The book is also important for the insight it provides into the attitude of the consumer under the British National Health Service. Ritchie soon had to abandon "private" medicine, even though covered by voluntary insurance. It is doubtful whether this book would have ever gotten written without the NHS. The author takes this for granted, and it is interesting to observe that the real difference between "private" and "state" medical care, as far as significance to this patient is concerned, was in the supportive and paramedical services (physical and speech therapy, transportation, orthopedic devices) available to him. The book is brief and reasonably priced. The only reason for not reading it would seem to be indifference.

Paths of Love. By VERCORS. 220 pages. Cloth. Putnam. New York. 1961. Price $4.00.

In this interesting French novel, Vercors investigates different facets of normal and neurotic love. There is the grandmother who—to keep her lover—lets him marry her daughter, and later, seduce her granddaughter. There is the millionaire with the passion for sticking a golden needle in the breasts of women. There is puppy love, masochistic abdication, late reunion. All these are presented with skill, culture, and a sad smile. Obviously, the author does not quite know the answer to the riddle of love, though he seems to indicate that no common denominator exists for such a many-faceted phenomenon. Although the author probably would reject this statement, at one point he gives the clue to the behavior of many of his victims of neurotic love: "I felt a certain form of masochism which thrilled me unconsciously."

Birth. Books 1 and 2. TULI KUPFERBERG, editor. 80 pages (each book). Paper. 222 East 21st Street, New York. 1960. Price $2.00 each.

These "books" are small volumes of what appear to be a new journal. They are reproductions of typewritten material and excerpts from various publications, and the reviewer is unacquainted with the editor or his qualifications. The treatment of the subjects is peculiar, in most cases sardonic. Book 1 contains material on alcohol, marijuana and peyote, and Book 2 covers opium, tobacco, tea and coffee, "various stimulants" and matter on stimulation and addiction.

These volumes are not professional medically and do not appear to be the productions of professional writers. However, professionals interested in the subjects covered by the contents should find them well worth looking at.

CONTRIBUTORS TO THIS ISSUE

HERMAN B. SNOW, M.D. Dr. Snow, born in New York City, is a graduate of the University of Syracuse College of Medicine in 1933. He is director of St. Lawrence State Hospital at Ogdensburg, N. Y. He is the author of numerous scientific papers including several on the open door hospital.

Dr. Snow was in military service in World War II and reached the rank of lieutenant colonel. He is certified in psychiatry by the American Board of Psychiatry and Neurology, is a fellow of the American Psychiatric Association, and is a qualified mental hospital administrator as certified by the committee on certification of mental hospital administrators of the American Psychiatric Association.

P. T. ANNESLEY, M.D. Dr. Annesley qualified to practise medicine in 1951, and, after a period of internships, started his psychiatric training in 1954, working at St. Clement's Hospital, the in-patient psychiatric unit of the London Hospital, and then at Park Prewett Hospital on the research project described in his article in this issue of THE QUARTERLY. He is now an assistant psychiatrist at St. Ebba's Hospital, Epsom, England.

FARUK BAYULKEM, M. D. A graduate of the medical school of Istanbul University, Dr. Bayulkem finished his psychiatry and neurology residency in Bakirkoy State Hospital under Dr. Mazhar Osman Uzman, the founder of the hospital. He served as assistant and clinical director at Bakirkoy for almost 10 years, and became superintendent of the hospital in 1960.

IBRAHIM TUREK, M.D. Dr. Turek, born in 1930, had 12 years of formal education prior to medical school. He is a graduate of the medical school of Istanbul University in 1954. He finished his neurological and psychiatric residency in Bakirkoy State Hospital under Faruk Bayulkem, M.D., in 1959. He entered the United States in January 1960. He worked six months in Letchworth Village, N. Y., a state school for the mentally defective, and served a second-year residency in psychiatry at Utica (N.Y.) State Hospital. He is now at Crownsville State Hospital, Crownsville, Md.

OSCAR PELZMAN, M.D. Dr. Pelzman received his medical degree at the Medical School of Vienna in 1936. After coming to the United States in 1941, he worked for a few years at Yale University as a pathologist. In 1946, he joined the staff of Central Islip (N. Y.) State Hospital, where he stayed for nine years. He is now in the full-time private practice of neuropsychiatry at Patchogue, N. Y.

H. AZIMA, M.D. Dr. Azima received his medical degree from the University of Kansas in 1948. He served junior and senior internships at Beth Israel Hospital in Newark, N. J., and the Bronx Hospital, New York City, from 1948 to 1950, studying analytic psychopathology at the New School, New York City, during 1949. He was assistant in psychiatry, then in neurology, and again in psychiatry, at the University of Paris from 1950 to 1953. He took the courses of Diploma of Psychopathology and Experimental Psychology at the University of Paris in 1952 and 1953 and of the Diploma of Psychiatry in 1953. He became senior assistant resident in 1953, and was later assistant in research and clinical fellow, at the Allan Memorial Institute, Montreal. He became clinical assistant at the Royal Victoria Hospital in Montreal in 1955 and the same year received his diploma in psychiatry, with the degree of M.Sc. (Psychiatry) from McGill University, Montreal. He has been on the faculty at McGill since 1955 and is now assistant professor of psychiatry there, and is assistant psychiatrist at the Royal Victoria Hospital. He is in psychoanalytic training with the Canadian Psychoanalytic Society in the McGill Psychoanalytic Training Program.

HERBERT S. PEYSER, M.D. A graduate of the College of Physicians and Surgeons, Columbia University in 1948, Dr. Peyser interned at Michael Reese Hospital, Chicago, and later was trained at the Bronx Veterans Administration Hospital, New York City. He was in military service from 1952 until early in 1954 when he returned to New York, became attached to the Mt. Sinai Hospital and began the private practice of psychiatry. He is assistant attending psychiatrist at Mt. Sinai and is a part-time psychiatrist (for psychotherapy) on the staff of Manhattan (N.Y.) State Hospital.

JULIAN MELTZOFF, Ph.D. Dr. Meltzoff is chief psychologist and assistant chief of the Psychiatric Day Center of the Veterans Administration Outpatient Clinic, Brooklyn. He graduated from the College of the City of New York in 1941, received his master's degree from the University of Pittsburgh in 1946, and was granted the Ph.D. degree by the University of Pennsylvania in 1950. He also studied at Columbia University and the Université de Nancy.

During World War II he served as a clinical psychologist in the European Theater of Operations. He was an intern in the Veterans Administration Psychology Training Program from 1946 to 1949. From 1950 to 1953 he served as assistant chief psychologist of the Veterans Administration Regional Office Mental Hygiene Clinic, Philadelphia, and was ap-

pointed chief psychologist at the Veterans Administration Hospital, Philadelphia, in 1953. He has been in his present position since 1954.

Dr. Meltzoff is a fellow of the American Psychological Association, and a member of the Eastern Psychological Association, the New Jersey Psychological Association, and the Society of Sigma Xi. He is the author of numerous research papers that have been published in various scientific journals and presented at professional meetings.

ABRAHAM A. RICHMAN, M.D. Dr. Richman received his B.S. from New York University, and is a graduate in medicine of the New York Medical College in 1931. He served as an intern at the Coney Island Hospital, Brooklyn, and did graduate work in neuropsychiatry at the Neurological Institute and Psychiatric Institute New York City. During World War II he was consulting neuropsychiatrist to the War Department. He is at present attending neuropsychiatrist at Coney Island Hospital, and associate neuropsychiatrist at Maimonides Hospital, Brooklyn. He became associated with the Veterans Administration in 1947, and now is chief of neurology and chief of the psychiatric day center at the Veterans Administration Outpatient Clinic, Brooklyn, N. Y.

Dr. Richman is a diplomate of the American Board of Psychiatry and Neurology, a fellow of the American Psychiatric Association, a member of the American Academy of Neurology, the Association for Research in Nervous and Mental Disease, Association for Advancement of Psychotherapy, New York Neurological Society, New York Society for Clinical Psychiatry, Brooklyn Neurological Society, and Brooklyn Psychiatric Society. Dr. Richman's major professional interests are in clinical neurology and preventive psychiatry.

ALLEN HANDFORD, M.D. Dr. Handford is a National Institute of Mental Health fellow in child psychiatry at St. Christopher's Hospital for Children, Philadelphia. He served his residency in general psychiatry at the Institute of Pennsylvania Hospital, Philadelphia. He was born and brought up in Des Moines, Iowa, received his A.B. from Harvard in 1953, and his M.D. from the State University of Iowa, College of Medicine, in 1957. He interned at Broadlawns Polk County Hospital, Des Moines. Dr. Handford is interested in the relationship between organic disease and mental illness in children, and in the psychotherapy of mentally ill children.

LAWRENCE LE SHAN, Ph.D. Dr. LeShan has been working on the problem of the psychosomatic aspects of cancer since 1952, under a grant from Frederick Ayer II. He was graduated with a B.A. in psychology

from the College of William and Mary in 1942, received his M.S. in psychology from the University of Nebraska in 1943, and his Ph.D. from the University of Chicago in 1954. Between his studies in Nebraska and Chicago, he had two terms of army service and was in the Veterans Administration Training Program. He has taught at Roosevelt University and the New School for Social Research. During his cancer research, he has served as chief of the department of psychology at the Institute of Applied Biology and at Trafalgar Hospital, New York City. Dr. Le Shan's wife is also a psychologist, and they have a small daughter.

HENRY HARPER HART, M.D. Dr. Hart, born in Toronto in 1896, attended public school in Sault Ste. Marie, Ontario, and high school in Montreal. He was graduated from McGill in 1916 and received his M.D. and C.M. degrees from McGill in 1922. After an internship at Royal Victoria Hospital in Montreal, he served as a medical officer of the Hudson's Bay Company, was on the staff of Boston Psychopathic Hospital, the Henry Phipps Psychiatric Clinic in Baltimore, and the Infirmary for Nervous Diseases in Philadelphia.

From 1939 to 1945 Dr. Hart trained at the New York Psychoanalytic Institute. He has been an instructor at the School of Applied Psychoanalysis, the New York Psychoanalytic Institute, since 1945. He is a member of the American Psychoanalytic Association, has been a member of the New York Psychoanalytic Society since 1947 and is a member of numerous other professional organizations. He has held a number of positions as associate or consultant in neurology and psychiatry. He was attending neurologist at the Neurological Institute from 1929 to 1951 and attending psychiatrist at the Vanderbilt Clinic from 1928 to 1951.

During World War I, Dr. Hart was in France with the Canadian Army Medical Corps and with a Canadian general hospital. He is the author of numerous psychiatric and psychoanalytic papers and has contributed previously to THE QUARTERLY.

HENRY B. ADAMS, Ph.D. Dr. Adams is a research clinical psychologist at McGuire Veterans Administration Hospital in Richmond, Va. Born in Charlotte, N. C., in 1925, he was in the army from 1943 to 1946. He received his A.B. from the University of North Carolina in 1949, his M.A. in psychology from Duke University in 1953 and his Ph.D. in psychology from Purdue in 1956.

Dr. Adams was a Veterans Administration clinical psychology trainee while he was a graduate student at Duke, and he later received a graduate

fellowship grant from the North Carolina State Board of Health. He interned in clinical psychology at Cleveland State Receiving Hospital and the State Psychiatric Institute, Cleveland, Ohio. He was later a Veterans Administration trainee at Purdue and worked at the Veterans Administration Hospital at Marion, Ind., and at the Indianapolis Veterans Administration Mental Hygiene Clinic.

Dr. Adams' doctoral dissertation at Purdue was in the general area covered by his contribution to this issue of THE QUARTERLY, although much of the work in this QUARTERLY paper was done later. After completing his doctorate, Dr. Adams was on the staff of the Nebraska Psychiatric Institute in Omaha and was instructor in medical psychology in the department of neurology and psychiatry of the University of Nebraska College of Medicine. He left there in 1959 to become a research clinical psychologist at the McGuire Veterans Administration Hospital. Besides his interest in the subject of his present paper, he is now engaged in research on the effects of sensory deprivation on psychiatric patients; psychological factors and emotional stresses as influences affecting the responses of tubercular patients to standard chemotherapy; personality traits and attitudes of nurses in Veterans Administration hospitals; and projective techniques.

NEWS NOTES

LAZAR IS NEW QUARTERLY ASSOCIATE EDITOR

Martin Lazar, M.D., director of Utica (N.Y.) State Hospital, has joined the editorial board of THE PSYCHIATRIC QUARTERLY as an associate editor. Besides long experience in general psychiatry, Dr. Lazar's special fields of interest and experience include mental deficiency, pediatrics and mental hospital administration. Dr. Lazar, born in New York City and a graduate of the College of the City of New York, received his medical degree in 1934 from the University of Glasgow Faculty of Medicine. After internship and a residency in medicine in England, he returned to the United States to enter the New York State mental hospital service at St. Lawrence State Hospital in 1937. He went to Hudson River State Hospital as a supervising psychiatrist in 1947, and in 1950 became assistant director of Willowbrook State School where he remained until his appointment as director of Utica State Hospital in 1959.

Dr. Lazar is a writer and teacher as well as a therapist and administrator. He has published scientific papers on mental defect and other subjects, and he was assistant clinical professor of pediatrics at New York University-Bellevue College of Medicine while he was at Willowbrook. He holds the certificate in mental hospital administration of the American Psychiatric Association and is a diplomate in psychiatry of the American Board of Psychiatry and Neurology.

NEW YORK STATE NARCOTIC ADDICT UNIT OPENS

The first of two new New York State Department of Mental Hygiene treatment and rehabilitation units for narcotic addicts opens this month at Central Islip State Hospital, it is announced by Paul H. Hoch, M.D., commissioner. There will be two wards, a 30-bed unit for admission and detoxication and a 50-bed ward for continued treatment and rehabilitation. The unit is under the administration of the hospital, of which Francis J. O'Neill, M.D., is director. Admissions are being restricted at first to patients from New York County (Manhattan). This is to permit development of the program before its extension to other downstate areas. A similar unit for the upstate area is being established at Utica State Hospital.

The Department of Mental Hygiene also has a narcotics research unit at Manhattan State Hospital.

RYAN NEW DIRECTOR OF MENTAL HEALTH ASSOCIATION

The National Association for Mental Health has announced the appointment of Philip E. Ryan as executive director. He has been executive

director of the National Health Council since 1953 and will take up his new post on May 1, 1961. A social worker who holds a master's degree from Notre Dame, Mr. Ryan directed the world-wide foreign war relief program of the American National Red Cross during World War II.

NEW YORK INCREASES PROFESSIONAL WORKERS' PAY

Substantial increases in the salaries of professional workers in the New York State Department of Mental Hygiene are included in general pay increases voted by the 1961 New York State Legislature. The higher pay scale, which benefits all civil service employees of the state, allows marked increases in the pay of professional workers, ranging from nurses to senior institution directors, and is intended to bring these positions more in line with those of persons in private employ or private practice, or in the civil service of some other jurisdictions.

ERICH KRAFT, M.D. PUPIL OF FREUD, DIES AT 68

Dr. Erich Kraft, New York City psychoanalyst and a former pupil of Sigmund Freud, died at his home in New York City on March 11, 1961 after a long illness, at the age of 68. Dr. Kraft was in private practice as a psychiatrist and psychoanalyst in Berlin before coming to this country in 1938. He had practised in New York since 1943.

NILES AND DIAMOND PROMOTED TO NEW POSTS

Charles E. Niles, M.D., assistant commissioner for administration of the New York State Department of Mental Hygiene, has been promoted to deputy commissioner for administration, effective April 15, 1961. Oscar K. Diamond, M. D., assistant director at Creedmoor State Hospital since 1956, has been named director of Manhattan State Hospital, Ward's Island, New York City, effective May 15, 1961. Dr. Niles has been in state service since 1926; and Dr. Diamond has been with the New York State Department of Mental Hygiene since 1946. Further biographical notes on both Dr. Niles and Dr. Diamond will appear in Part 1 of the 1961 PSYCHIATRIC QUARTERLY SUPPLEMENT.

PROFESSIONAL ASSOCIATIONS ELECT NEW OFFICERS

Lauretta Bender, M.D., was elected president and D. Ewen Cameron, M.D., was chosen as president-elect at the annual meeting of the American Psychopathological Association in New York City on February 24 and 25, 1961.

Professor Fritz Redl, Ph.D., of Wayne State University, Detroit, was named president of the American Orthopsychiatric Association at the conclusion of its annual meeting in New York City on March 25, 1961. Edward D. Greenwood, M.D., co-ordinator of the training program in child psychiatry for the Menninger School of Psychiatry, became president-elect.

Stewart Wolff, M.D., and Julius B. Richmond, M.D., took posts as president and president-elect at the annual meeting of the American Psychosomatic Society in Atlantic City, April 28 to 30, 1961.

NEW YORK MENTAL PATIENT POPULATION AGAIN DROPS

A reduction of 1,240 patients in the population of New York State mental hospitals during the past fiscal year is announced by Commissioner Paul H. Hoch, M.D., of the New York State Department of Mental Hygiene, in a report to Governor Rockefeller. This is the sixth consecutive fiscal year in which the population of the state's 18 mental hospitals has decreased. The peak population was reached in June 1955 with a total of 93,559. At the end of the 1960-61 fiscal year on March 31, 1961, the total was 87,370. Dr. Hoch cited new treatment methods and other developments as responsible for the decrease.

The population of the state schools for the mentally retarded, in contrast to that of the hospitals, continues to increase. Dr. Hoch reports a total of 23,325 for the fiscal year just ended, an expansion of 2,036 in the last five years.

HOSPITAL ALUMNI CONFER R. H. HUTCHINGS AWARD

The New York State Hospital Medical Alumni Association has conferred the R. H. Hutchings Award "for outstanding clinical service, writing and teaching" on Newton Bigelow, M.D., director of Marcy (N.Y.) State Hospital and former New York State Commissioner of Mental Hygiene. Dr. Bigelow is editor of this QUARTERLY, a position in which he succeeded Dr. R. H. Hutchings.

NEW YORK CITY MENTAL HEALTH DISTRICTS PLANNED

Plans for integrating New York City psychiatric services with the establishment of mental health districts inside the city were announced on March 22, 1961 by Commissioner Paul H. Hoch, M.D., of the New York State Department of Mental Hygiene. The plan, the commissioner said, will eventually provide for districts that will each be served by a state hospital, a city hospital or a voluntary hospital which will take care of both in-patient and out-patient needs. The city hospitals, according to

this plan, will be converted to facilities for emergency care, clinic services and short-term hospitalization. They now are generally considered primarily receiving centers. Because of administrative and legal problems, the new set-up is expected to require a considerable time for establishment.

The commissioner made the announcement at a meeting of the Bronx County Society for Mental Health which presented an award to him for "distinguished leadership in the field of mental health."

GERMAN JUNGIAN SOCIETY BEING FORMED

Tavistock Publications of London calls attention to a project for the formation of a German C. G. Jung Society. The move was gotten under way at a congress inspired by the Stuttgart society, *Arzt und Seelsorge,* in West Germany in June 1960. Dr. med. et phil. W. Bitter of Stuttgart organized the congress.

VERMONT UNIVERSITY HAS PSYCHIATRY DEPARTMENT

The University of Vermont announces the establishment of a department of psychiatry, previously taught as a division of the department of medicine. Thomas J. Boag, M.B., Ch.B., has been appointed chairman. A graduate of the University of Liverpool, he received his psychiatric training at McGill University.

MENTAL HEALTH CAREERS CAMPAIGN ANNOUNCED

An intensive campaign during Mental Health Week, April 30 to May 6, 1961, to interest young people in mental health careers, is announced by the New York State Department of Mental Hygiene. The department plans to bring opportunities in state mental health work to the attention of guidance directors in every high school in the state. A series of illustrated leaflets showing opportunities are being distributed. Individual pamphlets cover the careers of the psychiatrist, psychologist, psychiatric nurse, psychiatric social worker, occupational therapist, recreation instructor and attendant.

A new position, "training aide" in the state schools for the mentally retarded, has been announced by Deputy Commissioner Arthur W. Pense, M.D., of the New York State Department of Mental Hygiene. This new career position will be open to attendants of satisfactory educational qualifications and demonstrated ability with children. A special course to train these new aides has been opened.

JUDGE BAZELON IS MENNINGER VISITING PROFESSOR

Judge David L. Bazelon of the United States Court of Appeals for the District of Columbia Circuit is the seventeenth annual Alfred P. Sloan Visiting Professor to be named to lecture at the Menninger School of Psychiatry. Judge Bazelon, a lecturer on psychiatry and law at the University of Pennsylvania, is the author of the opinion of the United States Court of Appeals in the 1954 "Durham case." He formulated the rule in this case that "an accused is not criminally responsible if his unlawful act was the product of a mental disease or mental defect."

MEETINGS AND COURSES

The program has been announced for the International Congress for Psychoanalysis and Its Future Development, in Dusseldorf, Germany, September 6 to 11, 1961. The congress is being organized by the German Psychoanalytic Society; and the American, as well as European, societies will participate.

Other important meetings for the coming months include those of the American Psychiatric Association and the American Association on Mental Deficiency in May, and the Third World Congress of Psychiatry in Montreal in June.

A seminar in general semantics, with Gregory Bateson, Dean C. Barnlund and S. I. Hayakawa among the featured participants, will be conducted June 18-23, 1961 in Pleasanton, Calif., under the auspices of the Downtown Center of San Francisco State College.

Annual meetings for 1962 include those of the American Psychopathological Association in New York City, February 23 and 24; the American Orthopsychiatric Association in Los Angeles, March 22-24, and the American Psychosomatic Society in Rochester, N. Y., March 31 and April 1.

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